2009 Violations DOT

> 9532069 EPAHO042001121

| | | | | LEVEL |
|---|--|----------------------|---|--|
| TX090M0ECN01 | TXDPS COMMERCIAL VEHICLE ENFO | RCEMENI | CP#: 01518 | 18 1 |
| | SP PROG: INTERSTATE Y | RUCTION ZONE | ☑SIXED □ROADSIDW | ☐ ALCH ☐ DS |
| | 3 PTA HAVY | CR19UDC | HOUSE 2A201 | SM D TE |
| DATE: 01/22/2009 TIME: 6:55 AM Lessee/MC: CES ENVIRONMENTAL SERVICES: | | (1) IH-0010 | IN AUSTIN CO. (712-727) USBOT#: | MP#: 726 869392 |
| Add/City/St/Zio: 4904 GRIGGS ROAD HOUSTON, To | 77021 | | ICC/MC#: | 400234 |
| OWNER: STEVEN STRICKEER | | | TXDOT#: | 005516524C |
| ADD/CITY/ST/ZIP; (b) (6) | | | PHONE#: | 7136761460 |
| Operator: ROBERT JOE HICKMAN | RACE/SEX: | BM DOB: | (b) (6) MED CARD | : 08-30-2009 |
| Add/City/St/Zip: (b) (6) | | DL #: (b) | (6) ST: (b | DL CLASS: A |
| VEH SEARCH: YES NO REASON FOR | STOP: WARN CITATION C | NSPECTION. | CONTRABAND LOCATED: | □YES ☑NO |
| TYPE OF SEARCH: CONSENT DPC DINC. TO | | RABAND: 🔲 | DRUGS WEAPONS CUR | RENCY DOTHER |
| Unit TYPE N | | | | |
| La ST ST ST | 1112 | 6) | | |
| X | | | | |
| SIGNATURE: | | | 15 E TO 16 18 E E E E E E E E E E E E E E E E E E | 1 an 1 1 an 11 mai 1 mai 1 mai 1 mai 1 an mai 1 |
| T HEREBY PROMISE TO APPEAR AT THE TIME AND PLACE DESIGNATED IN THIS NOTICE. (THIS IS | | | | |
| NOT A PUBA OF GUILTY) | X(0)00(0)00(| (0) | | |
| ☑ COSA SECSIAED BA | GROSS WEIGHT: | O GROUP | P WEIGHT: | 0 |
| YOU ARE HEREBY NOTIFIED TO APPEAR | | LOAD D | ISP: | |
| JUDGE: Dennis R. King COUR | T: JP PCT./PLACE: 4/1 | PERMIT | #: | |
| PHONE: (979) 478-6723 ON/BEFORE Thu, 1 | 2~February-2009 AT 10:00:00AM | RG WT | #1 80000 GVWR | # 1 |
| ADDRESS: P. O. BOX 760 WALLIS TX 77485 | | RG WT | #2 GVWR | #2 |
| SEAL #'S REMOVED: DEST. SEAL #; INST. | ALLED CVSA DECAL-TT CVSA | DECAL-ST | CVSA DECAL-ST | |
| | | | | |
| SHIPPING #: NONE | CONSIGNOR: UNKNOWN | cc | ONGIGNEE: UNKNOWN | |
| COMMODITY: EMPTY | ORIGIN: HOUSTON | TX 74 | ESTINATION: ALLEYTON | TX |
| HM CATEGORY CODE: RQ? HW | PLACARDS REQ? 1 1/4 1 5/8 1 3/4 1 | 1/4 1 7/8 | ALLEGRÓ S | PRED |
| NA | | | SPEED LEM | |
| | SPEC. TANK AX 1 AA 2 AX 3 A , 1 1/4 1 1/2 1 7/8 2 | 1/4 2 3/8 | X 6 AX 7 AX 8 RADAR CAL | . : |
| TECKET VIOL. CITE # Bait. 005 005 POST Z | | | | : |
| No. Y/N DISP ACC | DRIVER: PLEASE COMPLY WITH DIRECTI | | SIDE OF THIS FORM | (b5) |
| 2 100 2 /// | OUT OF ADJUSTMENT - CLAMP / RO | TO - AXLE | 5 LEFT SIDE | 165 230 |
| Yes 393.47(A) 2 Yes D /h FRUM | S NOT MAINTAINED IN GOOD WORKIN CRACKED COMPLETLY THROUGH | IG ORDER (G | GENERAL) - AXLE 4XLEF | T SIME BRAKE |
| | ICIENT BRAKE LININGS - AXLE 4 LEFT | SIDE - LESS | THAN 1/4" | 266 |
| 393.47(E) 2 Yes D RAKE | OUT OF ADJUSTMENT - CLAMP / ROTO - | AXLE 4 LEFT | SIDE V | 1034 |
| 393.45(B)(2) 2 BRAKE | HOSE/TUBING CHAFING AND/OR KINKING | - AXLE 4 LE | FT SIDE | |
| | | | X | 75 |
| | VEHICLE/DRIVER OUT OF SERVICE NO | TICE | Duply (| JX' |
| ☑ VSHICLE Pursuant to authority dontained in TRC Cha | | = | authority contained in 008 | DISPOSITIONS |
| eclumn of this report. No person shall remove the | out of service stickers the declar | e the driver : | named on this report - Obt | Repaired at Scene / almed Oper, Auth. |
| applied to these vehicles or operate such vehicles defects have been repaired and the vehicles have b condition, or proper operating authority has been | cen restored to safe operating permit | | river to drive or Rep | Towed/Escorted to air Service Other |
| SEE CONTINUATION SHEET X TROOPER COMMENTS: | | | J. | Unknown Driver cos |
| T-YVIN 6PLACED COS AT TRUCK STO REPAIRED- | P 1H10 MP724 UNTIL | A. 15. | | |
| | X | v~V () | П | lay Book Exemption |
| | | Y RECEIVED | BĀ. | |
| 1 | DISTRICT/AREA TIME COMPLETED REPORT D 2 A 02 8:33AM REFER | PREPARED B BALLED | Y: J Pickett R Stavinoha | |
| CHARGES FILED BY: J Pickett 06210 2 A 02 | and the second s | INSTRUCTED | BY: 06210 2 A 02 | |

ANY ENTRIES IN THE VIOLATIONS' SECTION OF DRIVER'S COPY, WHERE THERE IS "YES" IN THE TICKET BOX, INDICATES CHARGES FILED AGAINST THE DRIVER. THIS WILL REQUIRE CONTACTING THE JUDGE FOR APPROPRIATE DISPOSITION.

JUDGE INFORMATION IS IN HEAVY BORDERED BOX ON DRIVER'S COPY.

PAYMENTS FOR FINES SHOULD BE SENT TO THE COURT LISTED ON THE DRIVER'S COPY.

DO NOT SEND PAYMENTS TO TX DPS/MCB.

| | CERTIFICATION OF REPAIRMAI PAIRS SHOWN IN THE "OUT OF SERV SATISFACTORILY COMPLETED. | | THE OTHER SIDE | | | | |
|--|--|----------------|----------------|--|--|--|--|
| SIGNATURE OF REPAIRMAN: | SIGNATURE OF REPAIRMAN: NAME OF SHOP (GARAGE): REPAIR WORK COMPLETED | | | | | | |
| CO 13/300 | Trus Makele Truck Soll C | DATE: /- 22:09 | TIME: 11:50 Am | | | | |
| MOTOR CARRIER CERTIFICATION OF ACTION TAKEN I CERTIFY THAT ALL VIOLATIONS NOTED UPON THIS REPORT HAVE BEEN CORRECTED AND ACTION HAS BEEN TAKEN TO ASSURE COMPLIANCE WITH THE MOTOR CARRIER SAFETY REGULATIONS INSOFAR AS THEY ARE APPLICABLE TO MOTOR CARRIERS AND DRIVERS. | | | | | | | |
| SIGNATURE OF CARRIER OFFICIAL: | TITLE: | DATE: | | | | | |

ATTENTION DRIVER:

This report must be furnished to the motor carrier whose name appears on this report.

ATTENTION DRIVER:

TRC Chapter 644, Revised Statutes, requires the Motor Carrier to execute the above certification

and return this report to:

MOTOR CARRIER BUREAU TEXAS DEPARTMENT OF PUBLIC SAFETY

PO BOX 4087 AUSTIN TX 78773-0521

IMPORTANT MESSAGES

Any enforcement actions taken against you and any subsequent court actions are intended to secure compliance with the traffic laws and all other users of the highways. Failure to comply with your written promise to appear in court as made on this citation will constitute a separate offense with which you may be charged and result in warrants being issued for your arrest. Failure to appear in court or failure to satisfy a judgement ordering payment of a fine and cost in the manner ordered by the court may result in the denial of renewal of your driver's license.

"A second or subsequent conviction of failure to maintain financial responsibility will result in the suspension of your driver license and motor vehicle registration unless you file and maintain proof of financial responsibility with the Department of Public Safety for two (2) years from the date of conviction. The Department may waive the requirements to file proof of financial responsibility if you file satisfactory evidence with the Department showing that at the time this citation was issued the vehicle was covered by a liability insurance policy or that you were otherwise exempt from the requirements to provide evidence of financial responsibility.

You may be able to require that this charge be dismissed by successfully completing a driving safety course or a motorcycle operator training course. You will lose that right if, on or before your appearance date, you do not provide the court with notice of your request to take the course. This article does not apply to an offense committed by a person who holds a commercial driver's license.

"A conviction of an offense under a traffic law of this state or a political subdivision of this state may result in the assessment on your driver's license of a surcharge under the Driver Responsibility Program."

A request for an out-of-service review, regarding operating authority, must be made in writing and forwarded to the manager of the Motor Carrier Bureau. If requested, a review will be scheduled and conducted by the manager of the Motor Carrier Bureau or the director's designee within 10 days of the issuance of the out-of-service order. A request for review should be addressed to the Texas Department of Public Safety, Motor Carrier Bureau, P.O. Box 4087, Austin, TX 78773-0521 or may be sent by facsimile transmission to (512) 424-5712 or via electronic mail at MotorCarrierBureau@txdps.state.tx.us. The Department may conduct the review by telephone conference call.

To obtain a TxDOT Motor Carrier Insurance Certificate or Single State Registration - contact the Texas Department of Transportation at 1-800-299-1700 or visit their website at www.dot.state.tx.us.

To obtain a USDOT Number contact the Federal Motor Carrier Safety Administration at 1-800-832-5660 or visit their website at www.fmcsa.dot.gov/factsfigs/formspubs.htm.

To obtain IFTA information contact the State of Texas Comptrollers Office at 1-800-252-1383 or visit their website at www.window.state.tx.us/taxinfo/fuels/ifta.html.

CVS-3a (12/03)



TXDPS COMMERCIAL
VEHICLE ENFORCEMENT

INSPECTION # TX090M0ECN01-0

MOTOR CARRIER

0151818

- . . .

1/22/2009 6:55:00AM

VEHICLE ENFORCEMENT CES ENVIRONMENTAL SERVICES INC

OPERATOR

<u>HICKMAN</u>

ROBERT

<u>JOE</u>

CONTINUATION SHEET

LAST NAME

FIRST NAME

MI

NOTE TO DRIVER: This report must be furnished to the motor carrier whose name appears on this report. NOTE TO MOTOR CARRIER: TRC Chapter 644 requires the Motor Carrier to execute the certification on the reverse side and return this report to Texas Department of Public Safety, Motor Carrier Safety Section, PO Box 4087. Austin, Texas 78773-0001 within fifteen (15) days.

| 1 | | | | VIOLATIONS | |
|---|-------------------|-----|------------------------------|--|---|
| | TICKET VIOL. CITE | | OOS COS POST Y/N DISP ACC | VIOLATIONS DISCOVERED | |
| i | 396.5(b) | 1 | | DIL/GREASE LEAK - OIL TANK BEHIND CAB | |
| 1 | 393.53(B) | 2 | i I | DEFECTIVE/INOPERATIVE AUTOMATIC SLACK (BRAKE) ADJUSTERS - AXLE 4 LEFT SIDE | |
| 1 | 393.53(B) | 2 | | DEFECTIVE/INOPERATIVE AUTOMATIC SLACK (BRAKE) ADJUSTERS - AXLE 5 RIGHT SIDE | |
| ! | 393,201 (d) | , 2 | | FRAME ACCESSORIES NOT BOLTED/RIVETED SECURELY - FENDER CRACKED LEFT SIDE OVER AXLE 2 | |
| - | 393.75(c) | 2 | | TIRE LESS THAN 2/32 OF AN INCH - AXLE 4 LEFT INSIDE | • |
| | | i | | AND ADDRESS OF THE CONTROL OF THE CO | |

| | VEHICLE/DRIVE | ER OUT OF SE | RVICE NOTICE | | |
|--|--|--------------|----------------------|--------------|----------------------|
| D verificia Pursuant to autor for Service" the vehicle column of this report, applied to these vehicle defects have been repail condition, or proper op SEE CONTINUATION SHEET | OOS DISPOSITIONS A. Repaired at Scood / Obtained Oper. Auth. B. Towed/Escorted to Repair Service D. Other U. Unknown N. Driver OOS | | | | |
| T-YVIN#750847327 REPAIRED- | PLACED OOS AT TRUCK STOP IH10 MP724 U | NTIL | V Robert J. | | 311 132 - 31 |
| | | | Λ | | ☐ Log Book Exemption |
| } | | | COPY RECEIVED BY | | - |
| INSPECTED BY: | ID/REGION/DISTRICT/AREA | | | J Pickett | • |
| J PICKETT | 06210 2 A 02 | 8:33AM | REFERRAL ID: | R Stavinoha | |
| CHARGES FILED BY: J Pi | ckett 06210 2 A 02 | • | BRAKES INSPECTED BY: | 06210 2 A 02 | - |

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DO NOT SEND PAYMENTS TO TX DPS/MCB.

CERTIFICATION OF REPAIRMAN I CERTIFY THAT THE REQUIRED REPAIRS SHOWN IN THE "OUT OF SERVICE" COLUMN ON THE OTHER SIDE OF THIS CERTIFICATE HAVE BEEN SATISFACTORILY COMPLETED. SIGNATURE OF REPAIRMAN: NAME OF SHOP (GARAGE): REPAIR WORK COMPLETED DATE: TIME: 1150 1-21-09 MES GNUNDORAL ENDYELL MOTOR CARRIER CERTIFICATION OF ACTION TAKEN I CERTIFY THAT ALL VIOLATIONS NOTED UPON THIS REPORT HAVE BEEN CORRECTED AND ACTION HAS BEEN TAKEN TO ASSURE COMPLIANCE WITH THE MOTOR CARRIER SAFETY REGULATIONS INSOFAR AS THEY ARE APPLICABLE TO MOTOR CARRIERS AND DRIVERS. SIGNATURE OF CARRIER OFFICIAL: TITI F: DATE:

ATTENTION DRIVER:

This report must be furnished to the motor carrier whose name appears on this report.

ATTENTION DRIVER:

TRC Chapter 644, Revised Statutes, requires the Motor Carrier to execute the above certification

and return this report to:

MOTOR CARRIER BUREAU
TEXAS DEPARTMENT OF PUBLIC SAFETY

1-21-0

PO BOX 4087

AUST!N TX 78773-0521

IMPORTANT MESSAGES

Any enforcement actions taken against you and any subsequent court actions are intended to secure compliance with the traffic laws and all other users of the highways. Failure to comply with your written promise to appear in court as made on this citation will constitute a separate offense with which you may be charged and result in warrants being issued for your arrest. Failure to appear in court or failure to satisfy a judgement ordering payment of a fine and cost in the manner ordered by the court may result in the denial of renewal of your driver's license.

"A second or subsequent conviction of failure to maintain financial responsibility will result in the suspension of your driver license and motor vehicle registration unless you file and maintain proof of financial responsibility with the Department of Public Safety for two (2) years from the date of conviction. The Department may waive the requirements to file proof of financial responsibility if you file satisfactory evidence with the Department showing that at the time this citation was issued the vehicle was covered by a liability insurance policy or that you were otherwise exempt from the requirements to provide evidence of financial responsibility.

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To obtain IFTA information contact the State of Texas Comptrollers Office at 1-800-252-1383 or visit their website at www.window.state.tx.us/taxinfo/fuels/ifta.html.

JUSTICE OF THE PEACE COURTS OF AUSTIN COUNTY, TEXAS RICHARD KANCEY, JP #1 THOMAS RICHTER, JP #2 DEŃNIS R. KING, JP #4 417N. Chelsey Suite A P.O. Box 176 P.O. Box 760 Industry, Pexas 78944 Beliville, Texas 77418 Wallis, Texas 77485 Phone: 979-865-9171 Phone: 979-357-4477 Phone: 979-478-6723 Eax: 979-357-4470 Fax: 979-865-8928 Fax: 979-478-7453 This form is furnished to you only as a courtesy. It is intended to assist you in understanding the charge(s) stated on the citation you received. If you have any questions about your rights or obligations you are encouraged to seek advise from the attorney of your choice. THIS FORM MUST BE RETURNED WITH YOUR REMITTANCE WHEN FINAL DISPOSITION IS MADE.

You must contact the Court, clearly defining your intentions by the due date of the citation. According to Sec. 543.009 Transportation Code—Violate Promise to Appear—(b) Any person willfully violating his written promise to appear in Court, given as provided in this section, is guilty of a misdemeanor regardless of the charge upon which he was originally arrested. (FAILURE TO APPEAR in Court may also result in the denial of renewal of your driver's license.) THIS WILL BE THE ONLY NOTICE YOU WILL RECEIVE, EXCEPT IN CASE OF A TRIAL SETTING.

If you wish to enter a "NOT GUILTY" plea to the charge(s), you must so indicate in the proper space provided. The charge(s) will be set on the TRIAL DOCKET for the next available opening.

If you wish to enter a plea of "GUILTY or NOLO CONTENDERE", please indicate below in the proper space provided. NOLO CONTENDERE means that you do not contest the State charge(s) against you. You will be found guilty on either plea with the fine being the same. Either plea indicates that you agree to waive your rights to an appearance before the Court for trial by JURY.

The Court prepared for your convenience, a list of contingent fines on the reverse side of this notice that will be acceptable. MasterCard, Visa, American Express or Western Union Quick Collect. (Court must be contacted to verify information needed.) Cashier's Check or Money Order's, made payable to Austin County. (No personal checks or partial payments accepted without Court approval.)

| | EQUESTED:YES | NO |
|--------------------|-------------------------------|---------------|
| Read all of the ab | ove carefully—before entering | a plea below. |
| NOT GUILTY | NOLO CONTENDERE | GUILTY |
| | | _ |
| | | |
| D DATED: | | |

NOTE: JUDGE CAN NOT DISCUSS PENDING CASES WITH YOU, UNLESS A WRITTEN PLEA OF GUILTY OR NOLO CONTENDERE HAS BEEN ENTERED.

01/08

NOTICE TO TRUCKING COMPANY

When making your remittance, refer to the DRIVER'S name &/or citation number, not the company name.

TRUCKS SCHEDULE OF CONTINGENT FINES

WEIGHT VIOLATIONS:

| " | |
|--|-----------|
| 0 to 5,000 lbs | \$254.00 |
| 5,001 to 7,000 lbs | |
| | |
| 7,001 to 10,000 lbs | \$824.00 |
| OVER 15,000 lbs | |
| | |
| No Commercial Driver's License | |
| Fail to Display Single State Registration. | |
| Operating Unregistered Truck or Trailer | |
| Fail to Produce Registration | |
| Expired Registration | |
| No Valid or Expired Inspection Certificate | \$154.00 |
| Fail to Cover Load or Loose Material Violation | \$210.00 |
| Equipment Violations | \$1-65.00 |
| Disregard Official Traffic Control Device | |
| Violations of Permit Regulation | |
| No Permit, All Regulations for Over Size & Weight Limits | |
| Hazardous Material Regulations | |
| No I.D. Signs on Trucks or Equipment | |
| Record of Duty Status not Current | |
| * | |
| Fail to Display TXDOT Registration Certificate | \$165.00 |
| *No Liability Insurance | |
| - | |

*Charge will be dismissed upon presentation to the Court of proof that the vehicle was covered by liability insurance policy at the time the citation was issued, and provided the proof is presented to the Court on or before your appearance date. A conviction of an offense under the Texas Motor Safety-Responsibility Act will result in the suspension of your driver's license and motor vehicle registration unless you provide and maintain proof of financial responsibility with the Department of Public Safety for two years from the date of conviction. The Department may waive the requirements to file proof of financial responsibility if you file satisfactory evidence with the Department showing that at the time the citation was issued, the vehicle was covered by liability insurance or that you were otherwise exempt from the requirements to provide evidence of financial responsibility.

CONTACT THE COURT ON VIOLATIONS NOT LISTED ABOVE

CES ENVIRONMENTAL SERVICES, INC. 4904 GRIGGS ROAD HOUSTON, TEXAS 77021 (713) 676-1460

BANK OF AMERICA, NA 35-2/1130

43157

2/11/2009

PAY TO THE ORDER OF

Judge Dennis R. King

**330.00

Three Hundred Thirty and 00/100**

Judge Dennis R. King

DOLLARS 🐧 🧱

MEMO

Ticket # TX090M0ECN01 - Robert Joe Hickman

#O43157#

43157

CES ENVIRONMENTAL SERVICES, INC.

Judge Dennis R. King

2/11/2009

Type Date

Bill

Original Amt. Balance Due

Discount

330.00

Payment 330.00

2/11/2009

Reference TX090M0ECN01

330.00

Check Amount

330.00

CES Environmental S Ticket # TX090M0ECN01 - Robert Joe Hickman

330.00

| 15EDEZ43463600 | | TXDPS COMMERC | IAL VEHICLE | NEODCEM | ENT | | | LEV | EL . |
|--|--|---|-------------------------------------|---|--|---|---------------------------------------|--|------|
| TX091S0E | フレクエ | IXDPS COMMERC | IAL VERICLE I | :NTORGEN | C | P#:(|)1518 | 18 ₁ | |
| ☐ ARREST TKT ☑ COM. VEH. ☐ ACCIDENT ☑ CDL | 9 - 15 PASS. FOR HIRE 16 PASS. FOR HIRE 16 PASS. NOT FOR HIRE SCHEDULE CHARTER | P PROG: | INTERSTATE INTRASTATE | NSTRUCTION YES OCCUPIE | NO | SCALE | □ROADSIDE | ALCH I | |
| DATE: 03/0 | 5/2009 TIME: 9:15 AM | COUNTY: CHAMBERS | g | WY: (1) IH- | -0010 IN | CHAMBERS | | 1) MP#: <u>81</u> | 5 |
| Lessee/MC: | | | | | | | USDOT#: ICC/MC#: | 869392 400234 | |
| Add/City/St/Zip: | CES ENVIRONMENTAL SERVICES IN | ic | | | | | TXDOT#: | 005516524C | |
| | 4904 GRIGGS ROAD HOUSTON, TX | | | | | | PHONE#: | 7136761460 | |
| 1 | JOSEPH PATRICK HERNANDEZ | | RACE/SEX | : <u>UM</u> D | oob: _(t | 0) (6) | _ MED CARD | : | |
| Add/City/St/Zip: | (b) (6) | | | _ DL # | #: <mark>(b) (6</mark> | <u> </u> | ST: TX | DL CLASS: A | |
| | YES NO REASON FOR S | | CITATION | | | | LOCATED: | | |
| TYPE OF SEARCH: | CONSENT PC INC. TO F | ARREST INVENTOR | RY TYPE OF | CONTRABAND | : □DRU | igs wea | APONS CUR | RENCY DOTHE | R |
| SIGNAT | Jewel 203 1 TR Cr 203 2 ST AN URE: SE TO APPEAR AT THE TIME AND ED IN THIS NOTICE. (THIS IS | HEV (L | (6) TX | b) (6) | | | | | |
| COPY RECEIVED | | GROSS WEIGHT: | ; | 33,760 | GROUP V | √EIGHT: | | 0 | - |
| YOU ARE HEREBY NO | | | | I | OAD DIS | P: | | | |
| JUDGE: | COURT | : | PCT./PLACE; | F | ERMIT # | : | | | |
| PHONE: | ON/BEFORE | | AT | 1 | RG WT #1 | | GVWR | | |
| ADDRESS: TX | | Torror | - DESCRIPTION OF | | RG WT #2 | | GVWR | #2 | |
| SEAL #'S REMOVED: | DEPT. SEAL #; INSTA | LLED CVSA | A DECAL-TT | CVSA DECAI | P-81. K | JVSA DECAL | ST | | |
| SHIPPING #: NOI | | CONSIGNOR: CE | S ENVIROMENT | | | | CES ENVIR | | |
| 31111110 11 | | | | - — — — — — — — — — — — — — — — — — — — | | SIGNEE: | PORT AURTI | | |
| COMMODITY: OI | L FIELD EQIPMENT HM CATEGORY CODE RQ? HW? | ORIGIN: HOT | USTON | ECEL EC | TX DEST | PINATION: | ALLEGED | | TX |
| | NA TO THE TAX TO THE T | | | | | | SPEED LI | TIM | |
| | | SPEC. TANK | AX 1 AX 2 A | X 3 AX 4 I | AX 5 AX | 6 AX 7 AX | 8 RADAR CA | ī. | |
| TICKET VIOL. CITE | # Unit OOS OOS POST No. Y/N DISP ACC | DRIVER: PLEASE C | | VIOLATIONS | | | TS FORM | | |
| 393.43 | | NOT PROTECTED IN | | | | | | | |
| | 1 SMOKIN | G VEHICLE (10 SECO | ONDS OR MORE) | - EXCESSIV | Æ SMOKE | | | | |
| 393.95(c) | | RE FUSES - NONE | | | | | | | |
| 393.95(a) | | XTINGUISHER VIOLA | | | | | | | |
| 391,45(b) | D EXPIRE | D MEDICAL EXAMINE | ERS CERTIFICAT | TE - 3/3/09 |) | FR. 1 . FFR. 1 | . Appr -P's assumer-" Meteoris | NETERICA MANERALISMO PAR ANTON TO | |
| | | | | | | | · · · · · · · · · · · · · · · · · · · | | |
| | | /EHICLE/DRIVER (| OUT OF SERV | CE NOTICE | _ | | | | |
| column of this re applied to these defects have beer condition, or pro | to authority contained in TRC Chap yehicle/s with defects followed by aport. No person shall remove the vehicles or operate such vehicles n repaired and the vehicles have be upper operating authority has been of | oter 644 I hereby de "YES" in the Out of out of service stic until the out of se | eclare "Out D f Service skere | | uant to au 644 I her driver na ice. No mo aquire dri | med on this tor carries ver to driv | report Of B. shall B. ce or Re | S DISPOSITIONS Repaired at Scentained Oper, Auti Towed/Escorted pair Service Other Unknown Driver OOS | h. |
| VINA <mark>(O) (O)</mark> | | | | | CEIVED BY | | | Log Book Exempt | ion |
| INSPECTED BY: | · · | | ME COMPLETED : 40AM | REFERRAL | | A Easo D Alva | | | |
| CHARGES FILED BY: | T | | | BRAKES INSI | | 1 | | η—— · | |

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DO NOT SEND PAYMENTS TO TX DPS/MCB.

| | CERTIFICATION OF REPAIRMAN | N . | |
|--------------------------------|----------------------------------|----------------|----------------|
| I CERTIFY THAT THE REQUIRED RE | EPAIRS SHOWN IN THE "OUT OF SERV | ICE" COLUMN ON | THE OTHER SIDE |
| OF THIS CERTIFICATE HAVE BEEN | SATISFACTORILY COMPLETED. | | |
| SIGNATURE OF REPAIRMAN: | NAME OF SHOP (GARAGE): | REPAIR WOR | K COMPLETED |
| Sull | CES ENU. + LOSSAMEN PARANCE | DATE: | TIME: 1640 |

MOTOR CARRIER CERTIFICATION OF ACTION TAKEN

I CERTIFY THAT ALL VIOLATIONS NOTED UPON THIS REPORT HAVE BEEN CORRECTED AND ACTION HAS BEEN TAKEN TO ASSURE COMPLIANCE WITH THE MOTOR CARRIER SAFETY REGULATIONS INSOFAR AS THEY ARE APPLICABLE TO MOTOR CARRIERS AND DRIVERS.

SIGNATURE OF CARRIED OFFICIAL: TITLE:

DATE:

3 22.09

ATTENTION DRIVER:

This report must be furnished to the motor carrier whose name appears on this report.

ATTENTION DRIVER:

TRC Chapter 644, Revised Statutes, requires the Motor Carrier to execute the above certification

and return this report to:

MOTOR CARRIER BUREAU TEXAS DEPARTMENT OF PUBLIC SAFETY

PO BOX 4087

AUSTIN TX 78773-0521

IMPORTANT MESSAGES

Any enforcement actions taken against you and any subsequent court actions are intended to secure compliance with the traffic laws and all other users of the highways. Failure to comply with your written promise to appear in court as made on this citation will constitute a separate offense with which you may be charged and result in warrants being issued for your arrest. Failure to appear in court or failure to satisfy a judgement ordering payment of a fine and cost in the manner ordered by the court may result in the denial of renewal of your driver's license.

"A second or subsequent conviction of failure to maintain financial responsibility will result in the suspension of your driver license and motor vehicle registration unless you file and maintain proof of financial responsibility with the Department of Public Safety for two (2) years from the date of conviction. The Department may waive the requirements to file proof of financial responsibility if you file satisfactory evidence with the Department showing that at the time this citation was issued the vehicle was covered by a liability insurance policy or that you were otherwise exempt from the requirements to provide evidence of financial responsibility.

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To obtain IFTA information contact the State of Texas Comptrollers Office at 1-800-252-1383 or visit their website at www.window.state.tx.us/taxinfo/fuels/ifta.html.

| TX090D0EGI04 | TXDPS COMMERCIAL VEHICLE EN | 7774 . 1767070 |
|---|---------------------------------|--|
| ☐ ARREST TKT ☐ 9 - 15 PASS. FOR HIRE | | CP#: U151818 2 |
| COM. VEH. 16 PASS, FOR HIRE | as spec. | TRUCTION ZONE FIXED ROADSIDE ALCH DS |
| ☐ ACCIDENT ☐ 16 PASS. NOT FOR HIRE ☑ CDL ☐ SCHEDULE ☐ CHARTER | | YES NO SCALE OCCUPIED HOUSE 1A501 SW TE |
| DATE: 01/13/2009 TIME: 12:57PM | | : (2) US-0059 IN CASS CO. (224-260) MP#: 232 |
| Lessee/MC: | | USDOT#: 869392 |
| Add/City/St/Zip: | | ICC/MC#: 400234 |
| OWNER: CES ENVIRONMENTAL SERVICES 1 | INC | TXDOT#: 005516524C |
| ADD/CITY/ST/ZIP:4904 GRIGGS ROAD HOUSTON, TO | ¢ 77021 | PHONE#: 7136761460 |
| Operator: BOBBY RODRIGUEZ | RACE/\$EX: | WM DOB; (b) (6) MED CARD: 8-6-10 |
| Add/City/St/Zip: (b) (6) | | DL #: (b) (6) ST: TX DL CLASS: A |
| VEH SEARCH: ☐ YES ☑ NO REASON FOR | STOP: WARN CITATION | INSPECTION CONTRABAND LOCATED: ☐YES ☑NO |
| TYPE OF SEARCH: CONSENT PC INC. TO | ARREST INVENTORY TYPE OF CO | NTRABAND: DRUGS WEAPONS CURRENCY OTHER |
| | IAKE CO# Plate Stat | AIU. |
| | PTRB 2002 (b) (6) TX (b) TX (b) | (6) |
| 2 ST F | RUE 247 | |
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| SIGNATURE: | | |
| I HEREBY PROMISE TO APPEAR AT THE TIME AND PLACE DESIGNATED IN THIS NOTICE. (THIS IS NOT A PLEA OF GUILTY) | X 00 00 | |
| COPY RECEIVED BY | GROSS WEIGHT: | GROUP WEIGHT: |
| YOU ARE HEREBY NOTIFIED TO APPEAR | | LOAD DISP: |
| JUDGE: COUF | RT: PCT./PLACE: | PERMIT #: |
| PHONE: ON/BEFORE | AT | RG WT #1 80000 GVWR #1 |
| ADDRESS: TX | | RG WT #2 0 GVWR #2 |
| SEAL #'S REMOVED: DEPT. SEAL #; INST. | alled CVSA DECAL-TT CV | SA DECAL-ST CVSA DECAL-ST |
| | | |
| SHIPPING #: 4251567 | CONSIGNOR: CES | CONSIGNEE: RINECO |
| COMMODITY: TOULENE | ORIGIN: HOUSTON | TX DESTINATION: BENTON AR |
| l | ? PLACARDS REQ? : | ALLEGED SPEED |
| | □ III | SPEED LIMIT |
| 1 J | SPEC. TANK AX 1 AX 2 AX 3 | AX 4 AX 5 AX 6 AX 7 AX 8 RADAR CAL. |
| | I. | |
| TICKET VIOL. CITE # Unit OOS OOS POST | | LATIONS DISCOVERED |
| No. Y/N DISP ACC | DRIVER:PLEASE COMPLY WITH DIREC | TIONS ON BACK SIDE OF THIS FORM |
| | | |
| | | |
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| | | |
| | | |
| | | |
| | VEHICLE/DRIVER OUT OF SERVICE | NOTICE VER Pursuant to authority contained in [OOS DISPOSITIONS] |
| UEHICLE Pursuant to authority contained in TRC Chapford of Service the vehicle/s with defects followed by column of this report. No person shall remove the | | Chapter 644 I hereby notify and A. Repaired at Scene / lare the driver named on this report Obtained Oper. Auth. |
| applied to these vehicles or operate such vehicles defects have been repaired and the vehicles have h | until the out of service Out | of Service. No motor carrier shall B. Towed/Escorted to mit or require driver to drive or Repair Service |
| condition, or proper operating authority has been SEE CONTINUATION SHEET TROOPER COMMENTS: | | rate any motor vehicle until D. Other U. Unknown |
| DEE CONTINUATION SHIEL INCOPER COMMENTS: | | N. Driver OOS |
| | V | ANS I |
| | <u>N</u> | 5og Book Exemption |
| INSPECTED BY: ID/REGION/ | | COPY RECEIVED BY ORT PREPARED BY: C Gray |
| 1 | | ERRAL ID |
| CHARGES FILED BY: | BRAF | (ES INSPECTED BY: |

| | | | |

ANY ENTRIES IN THE VIOLATIONS' SECTION OF DRIVER'S COPY, WHERE THERE IS "YES" IN THE TICKET BOX, INDICATES CHARGES FILED AGAINST THE DRIVER. THIS WILL REQUIRE CONTACTING THE JUDGE FOR APPROPRIATE DISPOSITION.

JUDGE INFORMATION IS IN HEAVY BORDERED BOX ON DRIVER'S COPY.

PAYMENTS FOR FINES SHOULD BE SENT TO THE COURT LISTED ON THE DRIVER'S COPY. DO NOT SEND PAYMENTS TO TX DPS/MCB.

CERTIFICATION OF REPAIRMAN

I CERTIFY THAT THE REQUIRED REPAIRS SHOWN IN THE "OUT OF SERVICE" COLUMN ON THE OTHER SIDE OF THIS CERTIFICATE HAVE BEEN SATISFACTORILY COMPLETED.

SIGNATURE OF REPAIRMAN:

NAME OF SHOP (GARAGE):

REPAIR WORK COMPLETED

TIME:

MOTOR CARRIER CERTIFICATION OF ACTION TAKEN
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SIGNATURE OF CARRIER OFFICIAL:

TITLE:

DATE:

ATTENTION DRIVER:

This report must be furnished to the motor carrier whose name appears on this report.

ATTENTION DRIVER:

TRC Chapter 644, Revised Statutes, requires the Motor Carrier to execute the above certification

MOTOR CARRIER BUREAU and return this report to:

TEXAS DEPARTMENT OF PUBLIC SAFETY

PO BOX 4087

AUSTIN TX 78773-0521

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To obtain IFTA information contact the State of Texas Comptrollers Office at 1-800-252-1383 or visit their website at www.window.state.tx.us/taxinfo/fuels/ifta.html.

| TX09040EGM03 | TXDPS COMMERCIAL VEHICL | E ENFORCEMENT | P#:0151 | Q1Q LEVEL |
|--|---|--|--|--|
| ☑ ARREST TKT ☐ 9 - 15 PASS. FOR HIRE | e e | | .r m . 0131 | 010 2 |
| ☐ COM. VEH. ☐ 16 PASS. FOR HIRE ☐ ACCIDENT ☐ 16 PASS. NOT FOR HIRE ☐ CDL ☐ SCHEDULE ☐ CHARTER | SP PROG: ☑ INTERSTATE ☐ INTRASTATE | T 122 F 140 | ✓FIXED □ROADSI SCALE HOUSE 2A701 | DE ALCH DS |
| DATE: 01/04/2009 TIME: 1:00PM | COUNTY: WALKER | _ | WALKER CO. (101~13 | ~ |
| | | | USDOT# | |
| Add/City/St/Zip: | | The state of the s | ICC/MC | #: 400234 |
| OWNER: CES ENVIRONMENTAL SERVICES I | | | TXDOT# | : 005516524C |
| ADD/CITY/ST/ZIP:4904 GRIGGS ROAD HOUSTON, TX Operator: BOBBY RODRIGUEZ | | EV. WM DOR. | PHONE# | ~ |
| Add/City/St/Zip: (b) (6) | RACE/S | EX: WM DOB: 1 | - | RD: 8-16-10 |
| VEH SEARCH: ☐ YES ☑ NO REASON FOR | STOP: WARN CITATION | | ST: T | |
| TYPE OF SEARCH: CONSENT PC INC. TO | | | · | |
| | IAKE CO# Plate Sta | at VIII. | | ORRENCTOTHER |
| 1111 | TRB (b) (6) R88012 TX | (b) (6) | = | |
| X 2 ST F | AU/2390 At | . . | | |
| SIGNATURE: | | | | 91 86 |
| ☐ I HEREBY PROMISE TO APPEAR AT THE TIME AND | | | | |
| PLACE DESIGNATED IN THIS NOTICE. (THIS IS NOT A PLEA CF GUILTY) | X(11120)00 | (35700)0 | (33800) | |
| COPY RECEIVED BY | GROSS WEIGHT: | 80,620 GROUP | WEIGHT: | . 0 |
| YOU ARE HEREBY NOTIFIED TO APPEAR | | LOAD DIS | P: | |
| JUDGE: James Mature COUR | T:JP PCT./PLACE | E: 4/0 PERMIT # | : | |
| PHONE: (936) 344-6119 ON/BEFORE Fri, 2 | 3-January-2009 AT 10:00 | OOAM RG WT #1 | 80000 GVW | R #1 |
| ADDRESS: 9360 HWY 75 SOUTH (POBOX 332) NEW WAV | ERLY TX 77358 | RG WT #2 | GVW | R #2 |
| SEAL #'S REMOVED: DEPT. SEAL #; INSTA | ALLED CVSA DECAL-TT | CVSA DECAL-ST | CVSA DECAL-ST | · · · · · · · · · · · · · · · · · · · |
| | | | J | |
| SHIPPING #: 4253924 | CONSIGNOR: LUBRIZOL | CON | SIGNEE: SWESTERN | |
| COMMODITY: PENTANE METHANOL | ORIGIN: DEER PARK | TX DES | TINATION: FREDONIA | . KS |
| | PLACARDS REQ? | | ALLEGE | |
| BULK 3 V | SPEC. TANK AX 1 AX 2 | AX 3 AX 4 AX 5 AX | SPEED : | |
| | 407 L | | | |
| TICKET VIOL. CITE # Unit OOS OOS POST | | VIOLATIONS DISCOVE | RED | |
| No. Y/N DISP ACC | DRIVER:PLEASE COMPLY WITH TIVE STOP LAMP (#) - REAR | | IDE OF THIS FORM | |
| ies 2 les A | 34,000 LBS. TANDEM AXLE - | 124.3 | 011/ | |
| les D | IVE STOP LAMP (#) - REAR RIG | | 213 | |
| D OVER A | LLOWABLE GROSS WEIGHT ~ 8062 | ر باملار 0/80000/520 | - 13 bil | |
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| ار در میدند به می در | memoran visitat masi pengapanan ang masara masa 1 saas saas sahih mera mbah sahin namen sahih Masara. | ma a fi salamana da a mahamma gaga mi era yay yayay ya seyiya ja mesi — era e q | Control and a Telegraphic Company and State Side was a suffer Side | ng province additional activities agreement of the second second |
| | | | | |
| | VEHICLE/DRIVER OUT OF SER | | | |
| VEHICLE Pursuant to authority contained in TRC Cha of Service" the vehicle/s with defects followed by | "YES" in the Out of Service | DRIVER Pursuant to au TRC Chapter 644 I her declare the driver na | eby notity and | COS DISPOSITIONS A. Repaired at Scene / Obtained Oper. Auth. |
| column of this report. No person shall remove the applied to these vehicles or operate such vehicles defects have been repaired and the vehicles have be | until the out of service | Out of Service. No mo permit or require dri | or carrier shall | B. Towed/Escorted to Repair Service |
| condition, or proper operating authority has been SEE CONTINUATION SHEET X TROOPER COMMENTS: | | operate any motor veh | icle until | D. Other U. Unknown |
| VIN# (b) (6) WK # 7136761460 CELL # (b) (6) | | Mi - | | N. Driver OOS |
| | , | X | 1 | Tion Book Warnetin |
| | | COPY RECEIVED BY | | Log Book Exemption |
| | DISTRICT/AREA TIME COMPLETED 2 2 A 07 ; 1:30PM | REPORT PREPARED BY: REFERRAL ID | A Morgan | |
| CHARGES FILED BY: A Morgan 09592 2 A 07 | 2 L AS U1 | BRAKES INSPECTED BY | | |

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SIGNATURE OF REPAIRMAN:

NAME OF SHOP (GARAGE):

REPAIR WORK COMPLETED

SEAU

DATE: 1-4-09 TIM

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SIGNATURE OF CARRIER OFFICIAL:

TULE:

DATE:

1-7-08

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TXDPS COMMERCIAL

TXDPS COMMERCIAL VEHICLE ENFORCEMENT

CONTINUATION SHEET

| INSECTION # | | СP | # | | | | | | • |
|----------------|-------------|----|---|---|---|-----|-----|------|---|
| TX09040EGM03-0 | . <u></u> - | | | Õ | 1 | 518 | 118 | | - |
| | | | | | | | | | |

MOTOR CARRIER

CES ENVIRONMENTAL SERVICES INC

OPERATOR

RODRIGUEZ
LAST NAME

BOBBY

DATE

FIRST NAME

MΙ

1/4/2009 1:00:00PM

NOTE TO DRIVER: This report must be furnished to the motor carrier whose name appears on this report. NOTE TO MOTOR CARRIER: TRC Chapter 644 requires the Motor Carrier to execute the certification on the reverse side and return this report to Texas Department of Public Safety, Motor Carrier Safety Section, PO Box 4087, Austin, Texas 78773-0001 within fifteen (15) days.

| | | • | | | | | (13) 333 |
|----------|-------|--------|------|-----|------|------|--------------------------------------|
| | | | | | | | VIOLATIONS |
| TICKET | VIOL. | CITE # | Unit | 005 | OOS | POST | VIOLATIONS DISCOVERED |
| | | | No. | Y/N | DISP | ACC | |
| | 393. | 25(£) | 1 | | | | DEFECTIVE STOP LAMP (#) - REAR RIGHT |
| <u> </u> | | |)) | |] | | 1 |
| | | | | | | | |

| | VEHICLE/DRIVI | ER OUT OF SER | VICE NOTICE | | |
|--|---|---------------------------------------|--|--|--|
| VEHICLE Pursuant to authority contain of Service" the vehicle/s with defect column of this report. No person sha applied to these vehicles or operate defects have been repaired and the vel condition, or proper operating author SEE CONTINUATION SHEET X TROOFER VIN# 513929 WK # 7136761460 CELL # | s followed by "YES" in the Ou Il remove the out of service such vehicles until the out o hicles have been restored to ity has been obtained. COMMENTS: | t of Service stickers f service | DRIVER Pursuant to author TRC Chapter 644 I hereby declare the driver named Out of Service. No motor permit or require driver operate any motor vehicl | notify and notify and conthis report carrier shall to drive or | OOS DISPOSITIONS A. Repaired at Scene / Obtained Oper. Auth. B. Towed/Escorted to Repair Service D. Other U. Unknown N. Driver OOS |
| | | 1 | X COPY RECRIVED BY | | Log Book Exemption |
| INSPECTED BY: | ID/REGION/DISTRICT/AREA | TIME COMPLETE | REPORT PREPARED BY: | A Morgan | |
| A MORGAN | 09592 2 A 07 | 1:30PM | REFERRAL ID · | | |
| CHARGES FILED BY: A Morgan 09592 | 2 A 07 | | BRAKES INSPECTED BY: | | |

| 1 | | JAMES F. MATURE | |
|-----------|---------|--|--|
| odnou Ro | | FUSTICE OF THE PEACE, PRECINCT FOUR WALKER COUNTY, TEXAS | |
| raney No. | driguez | D. BOX 332 NEW WAVERLY, TEXAS 77358 | |
| 109-9179 | 4-804-9 | Office # 936/344-6119 | |
| 109-9179 | 5/10/04 | Fax# 936/344-6033 | |
| Total - | Horas | <u> </u> | |

PAYING OVER THE PHONE CREDIT CARD INFORMATION

In order for the court to process your request you must submit the following information and sign the form below. If you have any questions please contact us at the number listed above.

****All information required for Credit Card Payment**** **NAME ON CITATION BOBBY RODRIGUEZ Citation Number TX09040 EGM 03
(Located at the top left on Commercial and the top right on NON Commercial) Visa Discover American Express (Check one) MasterCard NAME ON CREDIT CARD CES ENVIRONMENTAL SERVICE BILLING ADDRESS 4904 GRIGGS ROAD CITY HOUSTON STATE TX ZIP CODE 77021 PHONE # 713-676-1460 All phone number: 281-433-9792 CREDIT CARD NUMBER **Expiration Date** Signature Panel Code: DATE 1-23-09 **SIGNATURE**

Please Fax Information To: 936-344-6033

| Ø | Please fax receipt to the following fax number: | 713-676-167 | ⁷ 6 |
|---|---|---------------------|----------------|
| | | (Return fax number) | |

| TX09040EGM03 | TXDPS COMMERCIAL VEHICLE | ENFORCEMENT | 7D# . 01E10 | LEVEL |
|--|---|--|--|---|
| ☑ ARREST TKT ☐ 9 - 15 PASS. FOR | HIRE | | CP#:01518 | 18 2 |
| ☐ COM. VEH. ☐ 16 PASS. FOR HIRE ☐ ACCIDENT ☐ 16 PASS. NOT FOR ☐ CDL ☐ SCHEDULE ☐ CHA | | | FIXED TROADSIDE SCALE HOUSE 2A701 | ALCH DS |
| DATE: 01/04/2009 TIME: 1: | | | N WALKER CO. (101-133) | |
| Leasee/MC: | | | USDOT#: | 869392 |
| Add/City/St/Zip: | | | ICC/MC#: | 400234 |
| OWNER: CES ENVIRONMENTAL SER | and the second s | | TXDOT#: | 005516524C |
| ADD/CITY/ST/ZIP:4904 GRIGGS ROAD HOUS' Operator: BOBBY RODRIGUEZ | The state of the s | | PHONE#: | 7136761460 |
| operator. | RACE/SI | | (D) (b) MED CARD: | |
| Add/City/St/Zip: (b) (6) | N CON CHOR. FINANCE FINANCE | DL #: (b) | ST: <u>TX</u> | |
| | N FOR STOP: WARN CITATION | | CONTRABAND LOCATED: | UYES ☑NO |
| TYPE OF SEARCH: CONSENT DPC DIS | YPE MAKE CO# Plate Sta | | RUGS WEAPONS CURR | ENCY OTHER |
| 1 | TT PTRB 296 (b) (6) TX | (b) (6) | Tours and in North | |
| V - 1 2 | ST HEIL LT1264 AL | i. | <u> </u> | 16 10 2 10 4 10 6 E 10 11 12 10 10 |
| _ | • | | | |
| SIGNATURE: | 4C. This | | | |
| I HEREBY PROMISE TO APPEAR AT THE TI PLACE DESIGNATED IN THIS NOTICE. (TH NOT A PLEA OF GUILTY) | | (35700)0 | 0 (33800) | |
| COPY RECEIVED BY | GROSS WEIGHT: | 80,620 GROUP | WEIGHT: | . 0 |
| YOU ARE HEREBY NOTIFIED TO APPEAR | | LOAD DI | SP: | |
| JUDGE: James Mature | COURT: JP PCT./PLACE | :4/0 PERMIT | #: | |
| | Fri, 23-January-2009 AT 10:00: | OOAM RG WT # | 1 90000 GVWR | 11 |
| ADDRESS: 9360 HWY 75 SOUTH (POBOX 332) N | | RG WT # | | 12 |
| SEAL #'S REMOVED: DEPT. SEAL # | INSTALLED CVSA DECAL-TT | CVSA DECAL-ST | CVSA DECAL-ST | |
| <u> </u> | <u>L</u> | - k | l L | |
| SHIPPING #: 4253924 | CONSIGNOR: LUBRIZOL | CON | SIGNEE: SWESTERN | · ···· |
| COMMODITY: PENTANE METHANOL | ORIGIN: DEER PARK | TX DES | TINATION: FREDONIA | Ks |
| HM CATEGORY CODE BULK 3 | 2? HW? PLACARDS REQ? | | ALLEGED SI | |
| BOILK | SPEC. TANK AX 1 AX 2 | AX 3 AX 4 AX 5 AX | SPEED LIM | 1 |
| | 407 L | | | } |
| TICKET VIOL. CITE # Unit OOS ! OOS [POST | | VIOLATIONS DISCOVE | IRED | |
| No. Y/N DISP ACC | DRIVER:PLEASE COMPLY WITH D | IRECTIONS ON BACK S | | |
| Yes 393.25(f) 2 Yes A | DEFECTIVE STOP LAMP (#) - REAR OVER 34,000 LBS. TANDEM AXLE - | 143 | | |
| Yes | DEFECTIVE STOP LAMP (#) - REAR RIGH | | 215 | |
| D | OVER ALLOWABLE GROSS WEIGHT - 80620 | ראג | | |
| 393.25(f) 1 | DEFECTIVE STOP LAMP (#) - REAR LEFT | | ~ | ····· |
| Company of the service and resemble for the service and the se | ente entrus _{respo} subsequant es entres que transcentes en estable e constant dels entres entre entres entre entres ent | the Vincential and an extension of the particle of the second of the sec | and the home property and the Company of the state of the property and the state of | on the same consistency of the same and the |
| | | | | |
| | VEHICLE/DRIVER OUT OF SERV | ICE NOTICE | | |
| WERICLE Pursuant to authority contained in of Service" the vehicle/s with defects follows | TRC Chapter 644 I hereby declare "Out | DRIVER Pursuant to au TRC Chapter 644 I her | thority contained in OOS | DISPOSITIONS Repaired at Scene / |
| column of this report. No person shall rem applied to these vehicles or operate such w | ove the out of service stickers | declare the driver na Out of Service. No mo | med on this report Obta | ined Oper. Auth. |
| defects have been repaired and the vehicles | have been restored to safe operating | permit or require dri operate any motor veh | ver to drive or Repaired D. C | nir Service Other |
| SEE CONTINUATION SHEET X TROOPER COMM | NTS: | | | Jnknown Driver OOS |
| VIN# (b) (6) WK # 7136761460 CELL # (b) (| | 1 Ale | | - |
| | | Z /// | | og Book Exemption |
| INSPECTED BY: ID/R | GION/DISTRICT/AREA TIME COMPLETED | COPY RECEIVED BY | | |
| A MORGAN | 09592 2 A 07 1:30PM | REFERRAL ID | | · · · · · - · · · · · · · · · · · · · · |
| CHARGES FILED BY: A Morgan 09592 2 A | 07 | BRAKES INSPECTED BY | (; f = | |

***** DATE JAN-23-2009 ***** TIME 09:09 *****

DATE/TIME = JAN-23-2009 09:08

JOURNAL No. = 198

COMM. RESULT = OK

PAGE(S)

= 002

DURATION

= 00:00:58

FILE No.

= 726

MODE

= MEMORY TRANSMISSION

DESTINATION = 19363446033

RECEIVED ID =

RESOLUTION = STD

-CES Environmental Service-

***** DP-3010 *************

_ ***** _

713 676 1676- ******

| IS9DGP24548650000A | | | | | · | | | CVE-3 (Rev. 12/03 | |
|--------------------------------------|---|--|---|--|-----------------|------------------------------------|--------------------|--|-----|
| TX090X9D | GP06 | | HOUSTON | N POLICE DEPA | RTMENT | CP# : | 01518 | 818 2 | IL. |
| ARREST TKT | ☐ 9 ~ 15 PASS. E | | | | | O2 | V | | |
| COM. VEH. | 16 PASS. FOR I | | | | CONSTRUCTION 2 | ZONE FIXE | d F ROADSID | E | _ |
| ACCIDENT CDL | 16 PASS. NOT | | PROG: 🔽 | • | YES M | | | | |
|] — | | CHARTER | UAPRIC | | OCCUPIED | HOUSE | | Dsw Dr | E |
| | 2/2009 TIME: | 5:40PM CO | UNTY: HARRIS | <u></u> | HWY: (1) IH-00 | 610 IN HARRIS | | MP#: 29 | |
| Lessee/MC: | | | | | | 75 | USDOT#: | | |
| Add/City/St/Zip: | COO ENTERONOMIST | CERTONE THO | | | | | ICC/MC# | — | |
| J GIIII | CES ENVIRONMENTAL | | | | | | TXDOT#: | | |
| | 4904 GRIGGS ROAD H | OUSTON, TX 770 |)21 | | | (b) (c) | PHONE#: | | |
| 1 | WILFRIDO ABREU | | | RACE/SE | X: HM DOB | : (D) (O) | | RD: 03/19/2009 | |
| Add/City/St/Zip: | (b) (b) | | | | DL #: | (b) (6) | ST: TX | DL CLASS: A | |
| VEH SEARCH: | yes 🗹 no R | EASON FOR STOP | P: WARN | CITATION | DINSPECTION | ON CONTRAB | AND LOCATED: | ☐YES ØNO | |
| TYPE OF SEARCH: | CONSENT PC | INC. TO ARRI | es t 🔲 invent | TORY TYPE OF | CONTRABAND: | DRUGS 1 | WEAPONS C | URRENCY DOTHER | : |
| | | at the property of the state of | and the committee of the base of the case | Plate Stat | VIN | | | | _ |
| - | de la | 1 TT PTRE | | (b) (6) TX | | | | | |
| V (11451 | <u> </u> | 2 ST FRUI | <u>- </u> | , TX | <u> </u> | | | HAD 18 KU 1 AN I DOKUDO K 18 KU 18 K 18 K | |
| V | | | | ţ | | | | | |
| SIGNAT | | | | | | | | | |
| I HEREBY PROMI | SE TO APPEAR AT LACE DESIGNATED | | 3 | סייייצ | 011111 | | 00 | | : |
| IN THIS NOTICE A PLEA OF GUIL | . (THIS IS NOT | | _ | - | • | | | | |
| l | | GF | OSS WEIGHT: | • | G | ROUP WEIGHT: | | | |
| YOU ARE HEREBY N | BY: OTIFIED TO APPEAR | | .000 | _ | | AD DISP: | | | |
| JUDGE: | | COURT: | | PCT./PLACE: | .] | | | | |
| | ON/BE | | | AT | PER | RMIT #: | locus. | = +4 10 2 2 2 2 | |
| PHONE: | ON, D. | | | AI | | WT #1 1460 | | R #1 80000 | |
| ADDRESS: TX | | -51 | | | 100 | WT #2 0 | | R #2 | |
| SEAL #'S REMOVED: | DEPT. SEA | AL #; INSTALLE | D CV: | SA DECAL-TT | CVSA DECAL-S | ST CVSA DEC | AL-ST | | |
| | | | | | <u> </u> | | | <u> </u> | |
| SHIPPING #: | | C | ONSIGNOR: | | | CONSIGNEE: | | | İ |
| COMMODITY; RE | SIDUE | O! | RIGIN: HO | OUSTON | T | X DESTINATION | HOUSTON | 7 | ГX |
| L | HM CATEGORY CODE | | LACARDS REQ? | | | | ALLEGED | SPEED | |
| \ | BULK 3 | | <u> </u> | R | | | SPEED L | TIMIT | |
| | L | | SPEC. TANK | AX 1 AX 2 / | AX 3 AX 4 AX | 5 AX 6 AX 7 | AX 8 RADAR C | CAL. | |
| | • | \ | 312 | | | | | | : |
| TICKET VIOL. CITE | # Unit OOS OOS | POST | | | VIOLATIONS DI | PCOVERED | | | |
| 110/151 1445. 015= | No. Y/N DISP | ACC | | COMPLY WITH D | IRECTIONS ON | BACK SIDE OF | THIS FORM | | |
| 396.5(b) | 1 | OIL/GREAS | E LEAK - AXLE | E 1 RIGHT LEAK | ING BEARING F | LUID | | | |
| 396.5(b) | 1 | OIL/GREAS | E LEAK - AXLE | E 1 LEFT LEAKI | NG BEARING FL | UID | | | |
| 396.5(b) | | OIL/GREAS | E LEAK - AXLI | E 4 RIGHT LEAK | ING BEARING F | LUID | | | |
| | | | | | | | | | |
| | * | | | 6 | | | | | |
| | | | | | | | | | |
| | | | | | | | | | _ |
| | | | **** | - Surbe Adbi | | | | | |
| | | | | R OUT OF SERV | | | | • | |
| VEHICLE Pursuant | to authority contains | d in TRC Chapter | r 644 I hereby o | declare "Out | DRIVER Pursuan | t to authority o | ontained in | OOS DISPOSITIONS A. Repaired at Scene | a / |
| column of this re | port. No person shal Vehicles or operate s | T Lemove the dri | r or gerarde 20: | ickers | decrare the dr | iver named on the . No motor carri | iis report { | Obtained Oper. Auth B. Towed/Escorted to | ı_ |
| defects have been | repaired and the veh | icles have been | restored to say | | permit or requi | ire driver to dr | ive or | B. rowed/Escorted to Repair Service D. Other | ٥ ! |
| SEE CONTINUATION S | per operating authori HEET TROOPER | COMMENTS: | ilned. | | Obetate with mo | tor vehicle unti | | D. Other U. Unknown N. Driver OOS | |
| D/A= YES | | | | | | ····· | | N. Driver OUS | |
| WEATHER : CLEAR DRIVER ADVISED OF | VIOLATIONS | | | | V (TUNADO | > | ļ | | |
| DELLE 120 | 7 20 | | | \ <u> </u> | 1 | | | Log Book Exempti- | an |
| THORROWED DV. | | ID/REGION/DIS | morom/appa m | TME COMPLETED | COPY RECEI | | TOET | | |
| INSPECTED BY: GARZA, ERIC JOEL | | 2V-12801 | | 6:10PM | REFERRAL ID | (ED BI: GARGE | A, ERIC JOEL | | - |
| CHARGES FILED BY: | T | | | | BRAKES INSPEC | MINITO DV - | | | |

ANY ENTRIES IN THE VIOLATIONS' SECTION OF DRIVER'S COPY, WHERE THERE IS "YES" IN THE TICKET BOX, INDICATES CHARGES FILED AGAINST THE DRIVER. THIS WILL REQUIRE CONTACTING THE JUDGE FOR APPROPRIATE DISPOSITION. JUDGE INFORMATION IS IN HEAVY BORDERED BOX ON DRIVER'S COPY. PAYMENTS FOR FINES SHOULD BE SENT TO THE COURT LISTED ON THE DRIVERS COPY. DO NOT SEND PAYMENTS TO TX DPS/MCB. CERTIFICATION OF REPAIRMAN LOFRITIFY THAT THE REQUIRED REPAIRS SHOWN IN THE "OUT OF SERVICE" COLUMN ON THE OTHER SIDE OF THIS CERTIFICATE HAVE BEEN SATISFACTORILY COMPLETED. SIGNATURE OF REPAIRMAN: NAME OF SHOP (GARAGE): REPAIR WORK COMPLETED DATE: 2-2-09 MOTOR CARRIER CERTIFICATION OF ACTION TAKEN I CERTIFY THAT ALL VIOLATIONS NOTED UPON THIS REPORT HAVE BEEN CORRECTED AND ACTION HAS BEEN TAKEN TO ASSURE COMPLIANCE WITH THE MOTOR CARRIER SAFETY REGULATIONS INSOFAR AS THEY ARE APPLICABLE TO MOTOR CARRIERS AND DRIVERS. SIGNATURE OF CARRIER OFFICAL: TITLE: ATTENTION DRIVER: This report must be furnished to the motor carrier whose name appears on this report. ATTENTION DRIVER: TRC Chapter 644. Revised Statutes, requires the Motor Carrier to execute the above

IMPORTANT MESSAGES

PO BOX 4087

AUSTIN TX 78773-0521

certification and return this report to: MOTOR CARRIER BUREAU

TEXAS DEPARTMENT OF PUBLIC SAFETY

Any enforcement actions taken against you and any subsequent court actions are intended to secure compliance with the traffic laws and all other users of the highways. Failure to comply with your written promise to appear in court as made on this citation will constitute a separate offense with which you may be charged and result in warrants being issued for your arrest. The issuance of arrest warrants will make you subject to entry into the wanted persons file of this department. Failure to appear in court or failure to satisfy a judgement ordering payment of a fine and cost in the manner ordered by the court may result in the denial of renewal of your driver's license.

A second or subsequent conviction of failure to maintain financial responsibility will result in the suspension of your driver's license and motor vehicle registration unless you file and maintain proof of financial responsibility with the Department of Public Safety for two (2) years from the date of conviction. The Department may waive the requirement to file proof of financial responsibility if you file satisfactory evidence with the Department showing that at the time this citation was issued the vehicle was covered by a liability insurance policy or that you were otherwise exempt from the requirements to provide evidence of financial responsibility.

You may be able to require that this charge be dismissed by successfully completing a driving safety course or a motorcycle operator training course. You will lose that right if, on or before your appearance date, you do not provide the court with notice of your request to take the course. This article does not apply to an offense committed by a person who holds a commercial driver's license.

A request for an out-of-service review, regarding operating authority, must be made in writing and forwarded to the manager of the Motor Carrier Bureau. If requested, a review will be scheduled and conducted by the manager of the Motor Carrier Bureau or the director's designee within 10 days of the issuance of the out-of-service order. A request for review should be addressed to the Texas Department of Public Safety, Motor Carrier Bureau, P.O. Box 4087, Austin, TX 78773-0521 or may be sent by facsimile transmission to (512)424-5712 or via electronic mail at MotorCarrierBureau@txdps.state.tx.us. The Department may conduct the review by telephone conference call.

To obtain a TXDOT Motor Carrier Insurance Certificate or Single State Registration - contact the Texas Department of Transportation at 1-800-299-1700 or visit their website at www.dot.state.tx.us.

To obtain a USDOT Number contact the Federal Motor Carrier Safety Administration at 1-800-832-5660 or visit their website at www.fmcsa.dot.gov/factsfigs/formspubs.htm.

To obtain IFTA information contact the State of Texas Comptrollers Office at 1-800-252-1383 or visit their website at www.window.state.tx.us/taxinfo/fuels/ifta.html.

CVE-3 (Rev. 01/04)

| IS9DAR2454860000C3 | | CVE-3 (Rev. 12/03) |
|--|--|--|
| TX090S9DAR03 | PASADENA POLICE DEPARTMENT | CP#: 0151818 1 |
| ✓ ARREST TKT ☐ 9 - 15 PASS, FOR HIRE ✓ COM. VEH. ☐ 16 PASS, FOR HIRE | | |
| ACCIDENT 16 PASS. NOT FOR HIRE | CONSTRUCTION ZON SP PROG: ☑ INTERSTATE ☐ YES ☑ NO | E ☐FIXED ☑ROADSIDE ☐ ALCH ☐ DS |
| ☐ CDL ☐ SCHEDULE ☐ CHARTER | | HOUSE SW TE |
| DATE: 01/28/2009 TIME: 1:40Ph | 1 COUNTY: HARRIS HWY: (2) SH-0225 | in Harris co. (686-700) MP#: 692 |
| Lessee/MC: | | USDOT#: 869392 |
| Add/City/St/Zip: | | ICC/MC#: 400234 |
| OWNER: CES ENVIRONMENTAL SERVICE | s INC | TXDOT#: 005516524C |
| ADD/CITY/ST/ZIP:4904 GRIGGS ROAD HOUSTON, | TX 77021 | PHONE#: 7136761460 |
| Operator: ARTHUR NICKERSON | RACE/SEX: BM DOB: | (b) (6) MED CARD: EXEMPT |
| Add/City/St/Zip: (b) (6) | DL #: | ST: TX DL CLASS: C |
| VEH SEARCH: YES MO REASON FO | DR STOP: WARN CITATION INSPECTION | CONTRABAND LOCATED: ☐YES ☑NO |
| TYPE OF SEARCH: CONSERV PC INC. | TO ARREST TINVENTORY TYPE OF CONTRABAND: | DRUGS WEAPONS CURRENCY OTHER |
| | MAKE CO# Plate Stat VIN | |
| 1 TR | CHEV 107 (b) (6) TX | |
| X Who Sparano 2 ST | OTHR | |
| ^ | | |
| SIGNATURE: | | |
| ☑ I HEREBY PROMISE TO APPEAR AT THE TIME AND PLACE DESIGNATED | X(0)O(0)2 | XX (0) |
| IN THIS NOTICE. (THIS IS NOT A PLEA OF GUILTY) | | • • |
| ☑ COPY RECEIVED BY | GROSS WEIGHT: 0 GROV | UP WEIGHT: O |
| YOU ARE HEREBY NOTIFIED TO APPEAR | LOAD | DISP: |
| JUDGE: Pasadena Municipal Co | OURT:Municipal PCT./PLACE:0/1 PERMI | T #: |
| PHONE: (713) 475-9595 ON/BEFORE Fri | , 20-February-2009 AT 10:00:00AM RG WT | #1 44,000 GVWR #1 |
| ADDRESS: 1001-A E SHAW AVE PASADENA TX 7750 | FIG WT | #2 10,400 GVWR #2 |
| SEAL #'S REMOVED: DEPT. SEAL #; IN | STALLED CVSA DECAL-TT CVSA DECAL-ST | CVSA DECAL-ST |
| | | |
| SHIPPING #: | CONSIGNOR: | CONSIGNEE: |
| COMMODITY: EMPTY TRAILER | ORIGIN: HOUSTON TX | DESTINATION: DEER PARK TX |
| | HW? PLACARDS REC? HYD HYD SRG SRG | ALLEGED SPEED |
| NA. | n one see | SPEED LIMIT |
| | AX 1 AX 2 AX 3 AX 4 AX 5 | AX 6 AX 7 AX 8 RADAR CAL. |
| 200 | HYD HYD SRG SRG | |
| TICKET VIOL. CITE # Unit OOS OOS POST | VIOLATIONS DISC | OVERED |
| No. Y/N DISP ACC | DRIVER: PLEASE COMPLY WITH DIRECTIONS ON BAC | |
| Yes 393.209(d) 1 Yes U STE | ERING SYSTEM COMPONENT WORN/WELDED/MISSING | G - SEE COMMENTS (DRAG LINK TO PITMAN |
| Yes 396.17(c) 2 EXE | PIRED CMV INSPECTION CERTIFICATE / ANNUAL I | DOT - NONE |
| 391.11(b) (4) D Yes N OPE | RATING CMV W/O CORRECTIVE LENSES/HEARING AID - N | ON-CDL WITH "A" RESTRICTION |
| 393.11 2 DEF | ECTIVE ID LAMP (FRONT/REAR) - MISSING (REAR) RIG | HT |
| | | |
| 393.11 2 DEF | ECTIVE ID LAMP (FRONT/REAR) - MISSING (REAR) LEF | |
| | | |
| | VEHICLE/DRIVER OUT OF SERVICE NOTICE | |
| VEHICLE Pursuant to authority contained in TRC of Scrvice" the vehicle/s with defects followed | | authority contained in COS DISPOSITIONS hereby notify and A. Repaired at Scene / |
| column of this report. No person shall remove applied to these vehicles or operate such vehic | the out of service stickers declare the driver | named on this report Obtained Oper. Auth. o motor carrier shall B. Towed/Escorted to |
| defects have been repaired and the vehicles have condition, or proper operating authority has be | e been restored to safe operating permit or require en obtained. permit or require | driver to drive or Repair Service |
| SEE CONTINUATION SHEET X TROOPER COMMENTS | OTHER - | SEE COMMENTS U. Unknown N. Oriver OOS |
| (393.209(d)) MOTION, OTHER THAN ROTATIONAL, /SETCIC; DRIVER BACK IN-SERVICE WHEN HE WEAR | | |
| BOUND OUTSIDE MAIN LANE OF STATE EIGHWAY 225 | ■ A TO 0 = for a | D Log Book Exemption |
| | COPY RECEIVED | |
| | N/DISTRICT/AREA TIME COMPLETED REPORT PREPARED | BY: BELL, DONALD KEITH |
| AND ADD THE DV | 000427 2 9 W 2:17PM REFERRAL ID | Vav. |
| CHARGES FILED BY: BELL, DONALD KEITH 2W- | OUD427 2 9 W EXAMES INSPECTED | ^{3Y} : 2W-000427 2 9 W |

CVE-3a (12/03)





DEPARTMENT

| | II | NS | PΕ | CTIC |
|--|----|----|----|------|
| | | - | | T |
| | | | | |

X090S9DAR03-0

0151818

1/28/2009 1:40:00PM

CES ENVIRONMENTAL SERVICES INC

OPERATOR

CONTINUATION SHEET

LAST NAME

FIRST NAME

ΜI

NOTE TO DRIVER: This report must be furnished to the motor carrier whose name appears on this report. NOTE TO MOTOR CARRIER: TRC Chapter 644 requires the Motor Carrier to execute the certification on the reverse side and return this report to Texas Department of Public Safety, Motor Carrier Safety Section, PO Box 4087, Austin, Texas 78773-0001 within fifteen (15) days.

| | | | | VIOLATIONS |
|------------------|--------------|------------|----------------------|--|
| ICKET VIOL. CITE | # Unit No | OOS Y/N | OOS POST DISP ACC | VIOLATIONS DISCOVERED |
| 393.11 | 2 | | | DEFECTIVE ID LAMP (FRONT/REAR) - MISSING (REAR) CENTER |
| 392.33 | 2 | | | OPERATING CMV WITH LAMP/REFLECTOR OBSCURED - (REAR) TAIL, STOP, TURN SIGNAL (LEFT) |
| 393.9 | 2 | | | INOPERABLE (SPECIFY) LAMP (OTHER THAN HEAD/TAIL) - SIDE MARKER LAMP (REAR) LEFT |
| 393.95(f) | 1 | | | DEFECTIVE/IMPROPER WARNING DEVICE - NONE |
| 393.95(a) | : | | | FIRE EXTINGUISHER VIOLATION - NONE |

| | VEHICLE/DRIVER OUT OF SEI | RVICE NOTICE | |
|---|---|---|--|
| of Service" the vehicle/s wi column of this report. No p applied to these vehicles or defects have been repaired a | th defects followed by "YES" in the Out of Service erson shall remove the out of service stickers operate such vehicles until the out of service and the vehicles have been restored to safe operating authority has been obtained. | DRIVER Pursuant to authority contained in TRC Chapter 644 I hereby notify and declare the driver named on this report Out of Service. No motor carrier shall permit or require driver to drive or operate any motor vehicle until OTHER - SEE COMMENTS | OOS DISPOSITIONS A. Repaired at Scene / Obtained Oper. Auth. B. Towed/Escorted to Repair Service D. Other U. Unknown N. Driver COS |
| /SETCIC; DRIVER BACK IN-SERV | FHAN ROTATIONAL, >1/8"; DRIVER CLEAR LOCAL /ICE WHEN HE WEARS HIS CORRECTIVE LENSES; EAST STATE HIGHWAY 225 JUST EAST OF BEARLE | X (VILLE SPARMS) COPY RECEIVED BY | ☑ Log Book Exemption |
| INSPECTED BY: | ID/REGION/DISTRICT/AREA TIME COMPLETE 2:17PM | | |
| CHARGES FILED BY: | | BRAKES INSPECTED BY: | |

ANY ENTRIES IN THE VIOLATIONS' SECTION OF DRIVER'S COPY, WHERE THERE IS "YES" IN THE TICKET BOX, INDICATES CHARGES FILED AGAINST THE DRIVER. THIS WILL REQUIRE CONTACTING THE JUDGE FOR APPROPRIATE DISPOSITION.

JUDGE INFORMATION IS IN HEAVY BORDERED BOX ON DRIVER'S COPY.

PAYMENTS FOR FINES SHOULD BE SENT TO THE COURT LISTED ON THE DRIVER'S COPY. DO NOT SEND PAYMENTS TO TX DPS/MCB.

CERTIFICATION OF REPAIRMAN I CERTIFY THAT THE REQUIRED REPAIRS SHOWN IN THE "OUT OF SERVICE" COLUMN ON THE OTHER SIDE OF THIS CERTIFICATE HAVE BEEN SATISFACTORILY COMPLETED. SIGNATURE OF REPAIRMAN: NAME OF SHOP (GARAGE): REPAIR WORK COMPLETED DATE: TIME

MOTOR CARRIER CERTIFICATION OF ACTION TAKEN

I CERTIFY THAT ALL VIOLATIONS NOTED UPON THIS REPORT HAVE BEEN CORRECTED AND ACTION HAS BEEN TAKEN TO ASSURE COMPLIANCE WITH THE MOTOR CARRIER SAFETY REGULATIONS INSOFAR AS THEY ARE APPLICABLE TO MOTOR CARRIERS AND DRIVERS. SIGNATURE OF CARRIER OFFICIAL: TITLE: DATE:

ATTENTION DRIVER:

This report must be furnished to the motor carrier whose name appears on this report.

ATTENTION DRIVER:

TRC Chapter 644, Revised Statutes, requires the Motor Carrier to execute the above certification and return this report to:

MOTOR CARRIER BUREAU

TEXAS DEPARTMENT OF PUBLIC SAFETY

PO BOX 4087 AUSTIN TX 78773-0521

IMPORTANT MESSAGES

Any enforcement actions taken against you and any subsequent court actions are intended to secure compliance with the traffic laws and all other users of the highways. Failure to comply with your written promise to appear in court as made on this citation will constitute a separate offense with which you may be charged and result in warrants being issued for your arrest. Failure to appear in court or failure to satisfy a judgement ordering payment of a fine and cost in the manner ordered by the court may result in the denial of renewal of your driver's license.

"A second or subsequent conviction of failure to maintain financial responsibility will result in the suspension of your driver license and motor vehicle registration unless you file and maintain proof of financial responsibility with the Department of Public Safety for two (2) years from the date of conviction. The Department may waive the requirements to file proof of financial responsibility if you file satisfactory evidence with the Department showing that at the time this citation was issued the vehicle was covered by a liability insurance policy or that you were otherwise exempt from the requirements to provide evidence of financial responsibility.

You may be able to require that this charge be dismissed by successfully completing a driving safety course or a motorcycle operator training course. You will lose that right if, on or before your appearance date, you do not provide the court with notice of your request to take the course. This article does not apply to an offense committed by a person who holds a commercial driver's license.

"A conviction of an offense under a traffic law of this state or a political subdivision of this state may result in the assessment on your driver's license of a surcharge under the Driver Responsibility Program."

A request for an out-of-service review, regarding operating authority, must be made in writing and forwarded to the manager of the Motor Carrier Bureau. If requested, a review will be scheduled and conducted by the manager of the Motor Carrier Bureau or the director's designee within 10 days of the issuance of the out-of-service order. A request for review should be addressed to the Texas Department of Public Safety, Motor Carrier Bureau, P.O. Box 4087, Austin, TX 78773-0521 or may be sent by facsimile transmission to (512) 424-5712 or via electronic mail at Motor Carrier Bureau @txdps. state.tx.us. The Department may conduct the review by telephone conference çall.

To obtain a TxDOT Motor Carrier Insurance Certificate or Single State Registration - contact the Texas Department of Transportation at 1-800-299-1700 or visit their website at www.dot.state.tx.us.

To obtain a USDOT Number contact the Federal Motor Carrier Safety Administration at 1-800-832-5660 or visit their website at www.fmcsa.dot.gov/factsfigs/formspubs.htm.

To obtain IFTA information contact the State of Texas Comptrollers Office at 1-800-252-1383 or visit their website at www.window.state.tx.us/taxinfo/fuels/ifta.html.

CES ENVIRONMENTAL SERVICES, INC. 4904 GRIGGS ROAD HOUSTON, TEXAS 77021

(713) 676-1460

BANK OF AMERICA, NA 35-2/1130

43158

2/11/2009

PAY TO THE ORDER OF _

Pasadena Municipal

**530.00

Five Hundred Thirty and 00/100***

_ DOLLARS f 🧱

Pasadena Municipal

MEMO

© 2005 RYDIT INC. # 785 1-800-425-5910

TX090S9DAR03 - Arthur Nickerson

#O43158#

43158

CES ENVIRONMENTAL SERVICES, INC.

Pasadena Municipal

2/11/2009

mitt Bown

Date Type Reference Original Amt.

Balance Due Discount Payment

2/11/2009 Bill TX090S9DAR03 530.00

530.00 Check Amount 530.00 530.00

CES Environmental S TX090S9DAR03 - Arthur Nickerson

530.00

| 13BM024340000000 | · | | | | |
|--|--|---|-------------------------------------|-------------------------------------|--|
| Тх09100вмо03 | | RCIAL VEHICLE ENFORC | EMENT CP | #:0151 | 818 1 |
| ☐ ARREST TKT ☐ 9 - 15 PA ☐ COM. VEH. ☐ 16 PASS. ☐ ACCIDENT ☐ 16 PASS. | FOR HIRE | CONSTRUCT | | Fixed ⊟ROADSID | E ALCH DS |
| ☑ CDL ☐ SCHEDULE | CHARTER | · · · · · · · · · · · · · · · · · · · | PIED | HOUSE 2A701 | SW TE |
| DATE: 02/05/2009 TIM | C: 10:15 AM COUNTY: WALKER | HWY: (1) | IH-0045 IN WA | LKER CO. (101-133 | |
| Add/City/St/Zip: | | · | | USDOT#: | |
| OWNER: CES ENVIRONMEN | TAL SERVICES INC | | | TXDOT#: | |
| ADD/CITY/ST/ZIP:4904 GRIGGS RO | AD HOUSTON, TX 77021 | : | | PHONE#: | |
| Operator: ROLANDO MORA | ES | RACE/SEX: HM | DOB: (b) | 6) | D: 7/21/09 |
| Add/City/St/Zip: (b)(6) | | D | L#: (b) (6) | ST: TX | DL CLASS: A |
| VEH SEARCH: TYES VO | REASON FOR STOP: WARN | CITATION INSE | PECTION CON | TRABAND LOCATED: | □YES ☑NO |
| TYPE OF SEARCH: CONSENT I | | | | | RRENCY OTHER |
| | Unit TYPE MAKE CO# | In a min a community | | | |
| | 1 TT PTRB 298 2 ST OTHR 257 | (D) (Q) TX | | | |
| X Haland Morals | | | | | |
| signature: | | | | 7(1 to 10 littoro (4 logino) | I MET E DV 6000 E OLDENNE O DATAMET I MET. |
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| PLACE DESIGNATED IN THIS NOT NOT A PLEA OF GUILTY) | ICE. (TRIS IS X OO | 00 | | | |
| COPY RECEIVED BY | GROSS WEIGHT: | | GROUP WEI | GHT: | |
| YOU ARE HEREBY NOTIFIED TO APPE | | | LOAD DISP: | | |
| JUDGE: | COURT: | PCT./PLACE: | PERMIT #: | | |
| | I/BEFORE | AT | RG WT #1 8 | | |
| ADDRESS: TX | | | RG WT #2 0 | | 68000 |
| SEAL #'S REMOVED: DEPT | | SA DECAL-TT CVSA DE 16576 991657 | | A DECAL-ST | |
| | <u> </u> | | | | |
| SHIPPING #: 005591309 | CONSIGNOR: C | ES ENVIRONMENTAL SEI | CATCES CONSIGN | VEE: CES ENVI SERVICES | |
| COMMODITY: FLAMMABLE LIQUI | | OUSTON | TX DESTINA | | KS |
| HM CATEGORY | CODE RQ? HW? PLACARDS REQ? | R 1 11/8 1 11/4 | 1 1/4 | ALLEGED SPEED L | i |
| | SPEC, TANK | AX 1 AX 2 AX 3 AX 4 | AX 5 AX 6 A | | |
| | 307 | 1 1 1/8 1 1 1/4 | 1 1/2 | | İ |
| | OOS POST | VIOLATIO | NS DISCOVERED | <u> </u> | |
| No. Y/N D 177.817(a) D | | COMPLY WITH DIRECTIONS PROPERLY PREPARED SHIPE | | | PMCV PESDONSE |
| 177.817(a) | PHONE NUMBER | FROFEREI FREFARED SRIFE | ING PAPERS - | NO READADE EVEN | ZENCI RESPONSE |
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| | | OUT OF SERVICE NOTI | | <u></u> | |
| VEHICLE Pursuant to authority cont of Service" the vehicle/s with del | ained in TRC Chapter 644 I hereby o ects followed by "YES" in the Out o | declare "Out DRIVER Pu | rsuant to author er 644 I hereby | ity contained in C | OS DISPOSITIONS Repaired at Scene / |
| column of this report. No person applied to these vehicles or opera | shall remove the out of service sti te such vehicles until the out of s | ickers declare t service Out of Se | he driver named rvice. No motor | on this report C carrier shall B | btained Oper. Auth. . Towed/Escorted to |
| condition, or proper operating aut | vehicles have been restored to sat | | require driver | | epair Service |
| IODE COMPTHINGTON CHEER PDOC | | operate a | ny motor vehicle | | |
| | hority has been obtained. ER COMMENTS: | operace a | my motor ventcre | įū | . Unknown . Driver 005 |
| TESTING - Y TRUCK VIN - 7D742270 | | V A | ny motor ventore | įū | . Unknown |
| TESTING - Y | ER COMMENTS: | 1993, PGIII X A. | ud. Words | | . Unknown |
| TESTING - Y TRUCK VIN - 7D742270 TRAILER VIN - 955192 RQ, WASTE FLAMMABLE LIQUIDS, N.O | ER COMMENTS: S. (PENTANE, METHANOL), 3, UN | 1993, PGIII X COPY I | d. Worls | U N | . Unknown . Driver 005 |
| TESTING - Y TRUCK VIN - 7D742270 TRAILER VIN - 955192 | ER COMMENTS: S. (PENTANE, METHANOL), 3, UN ID/REGION/DISTRICT/AREA | 1993, PGIII X COPY 1 [ME COMPLETED REPORT PROBLEM REFERRAL | L Woll RECEIVED BY REPARED BY: | | . Unknown . Driver 005 |

ANY ENTRIES IN THE VIOLATIONS' SECTION OF DRIVER'S COPY, WHERE THERE IS "YES" IN THE TICKET BOX, INDICATES CHARGES FILED AGAINST THE DRIVER. THIS WILL REQUIRE CONTACTING THE JUDGE FOR APPROPRIATE DISPOSITION.

JUDGE INFORMATION IS IN HEAVY BORDERED BOX ON DRIVER'S COPY.

PAYMENTS FOR FINES SHOULD BE SENT TO THE COURT LISTED ON THE DRIVER'S COPY.

DO NOT SEND PAYMENTS TO TX DPS/MCB.

| I CERTIFY THAT THE REQUIRED RE OF THIS CERTIFICATE HAVE BEEN | PAIRS SHOW | | | ON THE OTHER SIDE |
|--|---------------------------|-------------------|---------------|-------------------|
| SIGNATURE OF REPAIRMAN: | NAME OF SH | OP (GARAGE): | REPAIR W | ORK COMPLETED |
| | | | DATE: | TIME: |
| | | | | |
| MOTOR CA I CERTIFY THAT ALL VIOLATIONS A BEEN TAKEN TO ASSURE COMPLI THEY ARE APPLICABLE TO MOTOR | NOTED UPON ANCE WITH 1 | THE MOTOR CARRIER | BEEN CORRECTE | |
| SIGNATURE OF CARRIER OFFICIAL: | TITLE: | Minager | DATE: 3-4-20 | 9 |

ATTENTION DRIVER:

This report must be furnished to the motor carrier whose name appears on this report.

ATTENTION DRIVER:

TRC Chapter 644, Revised Statutes, requires the Motor Carrier to execute the above certification

MOTOR CARRIER BUREAU

TEXAS DEPARTMENT OF PUBLIC SAFETY

PO BOX 4087

and return this report to:

AUSTIN TX 78773-0521

IMPORTANT MESSAGES

Any enforcement actions taken against you and any subsequent court actions are intended to secure compliance with the traffic laws and all other users of the highways. Failure to comply with your written promise to appear in court as made on this citation will constitute a separate offense with which you may be charged and result in warrants being issued for your arrest. Failure to appear in court or failure to satisfy a judgement ordering payment of a fine and cost in the manner ordered by the court may result in the denial of renewal of your driver's license.

"A second or subsequent conviction of failure to maintain financial responsibility will result in the suspension of your driver license and motor vehicle registration unless you file and maintain proof of financial responsibility with the Department of Public Safety for two (2) years from the date of conviction. The Department may waive the requirements to file proof of financial responsibility if you file satisfactory evidence with the Department showing that at the time this citation was issued the vehicle was covered by a liability insurance policy or that you were otherwise exempt from the requirements to provide evidence of financial responsibility.

You may be able to require that this charge be dismissed by successfully completing a driving safety course or a motorcycle operator training course. You will lose that right if, on or before your appearance date, you do not provide the court with notice of your request to take the course. This article does not apply to an offense committed by a person who holds a commercial driver's license.

"A conviction of an offense under a traffic law of this state or a political subdivision of this state may result in the assessment on your driver's license of a surcharge under the Driver Responsibility Program."

A request for an out-of-service review, regarding operating authority, must be made in writing and forwarded to the manager of the Motor Carrier Bureau. If requested, a review will be scheduled and conducted by the manager of the Motor Carrier Bureau or the director's designee within 10 days of the issuance of the out-of-service order. A request for review should be addressed to the Texas Department of Public Safety, Motor Carrier Bureau, P.O. Box 4087, Austin, TX 78773-0521 or may be sent by facsimile transmission to (512) 424-5712 or via electronic mail at MotorCarrierBureau@txdps.state.tx.us. The Department may conduct the review by telephone conference call.

To obtain a TxDOT Motor Carrier Insurance Certificate or Single State Registration - contact the Texas Department of Transportation at 1-800-299-1700 or visit their website at www.dot.state.tx.us.

To obtain a USDOT Number contact the Federal Motor Carrier Safety Administration at 1-800-832-5660 or visit their website at www.fmcsa.dot.gov/factsfigs/formspubs.htm.

To obtain IFTA information contact the State of Texas Comptrollers Office at 1-800-252-1383 or visit their website at www.window.state.tx.us/taxinfo/fuels/ifta.html.

8250

Louisiana Department of Transportation and Development

Attn: Weights & Standards Office P.O. Box 94042, Baton Rouge, LA. 70804-9042

Issued the 18th day of March, 2009 at 06:15 PM Highway: I-10 W Parish: Calcasieu

VT# 0701CW-13.DL00108(0) Driver Last Name: DOMINGUEZ, First Name: JOSE M.I. L Suffix: Street Address: (b) (6) ZIP: State: b) (6) Phone: Operator License Number: 6 Class: A State of Issue: TX D.O.B. Owner DBA Name: CES ENVIRONMENTAL SERVICES INC Name: Street Address: 4904 GRIGGS RD Street Address: City: HOUSTON, State: TX ZIP: 77021 City: , State: ZIP: Phone: Phone: (713) 676-1460 Vehicle Information Is Apportioned Vehicle D.O.T number Vehicle Year Vehicle Make Vehicle VIN Number 2004 PTRB 869392 License State License Number Registered Weight License Year 2008 ΤX 80.000 Primary Trailer Information 2nd Trailer Information Primary Trailer State Primary Trailer License N 2nd Trailer State 2nd Trailer License No W19940 NA TX NA Permit Information Expired 48 Hour Permit No. Valid 48 Hour Permit No. Expired Permit No. Valid Permit No. Permitted Weight: Control Number: Commodity Code Description LB SODIUM HYDROXIDE R.S. No. Violation: Fine Description 32:386 1. Over Legal Gross Vehicle Weight or Over Legal Axle Weight \$0.00 Type: Type 6 Tire width on steering axle: 11.00 No. Of Axles Sets: 3 Non-Interstate: 80000 Maximum allowable legal / permitted weight - Interstate: 80000 Axle Set Axle Set 1 Axle Set 2 Axle Set 3 Tandem Type Steering Axle Tandem Legal Weight 15.000 34.000 34,000 Scale Weight 34,600 31,980 9,980 Over Weight 600 Fine \$0.00 \$10.00 \$0.00 Weight Table Fine Summary G.V.W. **GVW** Overage Over GVW lb Over GVW \$ Individual Axle Fines Primary Fine Multiple Violation 76,560 \$0.00 \$10.00 \$10.00 \$0.00 0 Remarks: Driver was given the opportunity to shift, but was unable to legalize Violation Number: 0701CW-13.DL00108(0) Total Fine Is: \$10.00

Officer

Douglas K Levingston

DK Levin goston



Control Number: 0701CW-DL000148

Issued the 18th day of March, 2009 at 06:31 PM

V.T. 0701CW-13.DL00108(1)

| Highway | Parish | Statute | Issuing Officer |
|-------------------------------|----------------------|---------|----------------------|
| I-10 | Calcasieu | 32:386 | Douglas K Levingston |
| Cash | | | |
| escription: DRIVER PAID TODAY | | | |
| | Staten | nent | |
| | Fine Amount | \$10.00 | |
| Amount P | aid (prior receipts) | \$0.00 | |
| | Balance | \$10.00 | |
| Amou | nt of this payment | \$10.00 | |
| Balance Due | after this payment | \$0.00 | |
| | Payment | History | |
| No prior receipts. | | | |

Disposition Code: 02

| Driver | | | | | | | | |
|---|--------------|---------------------------------|--------|-----------------|---------------|----------------------------|--|--|
| Name: JOSE L I | DOMINGUEZ | | | | | | | |
| Last Name: DOMINGUEZ, First Name: JOSE M.I. L Suffix: | | | | | | | | |
| Street Address: City: (b) (6) | (b) (6) | ZIP <mark>(b) (6)</mark> Phone: | | | | | | |
| | | 44 Class: A State of Issue | : TX | | | | | |
| Owner | | | | DBA | | | | |
| Name: CES ENVIRONMENTAL SERVICES INC | | | | Name: | | | | |
| Street Address: 4904 GRIGGS RD | | | | Street Address: | | | | |
| City: HOUSTON, State: TX ZIP: 77021 | | | | City: , | State: ZIP: | | | |
| Phone: (713) 676-1460 | | | | Phone: | | | | |
| Vehicle Year | Vehicle Make | Vehicle VIN Number | Licens | e Year | License State | License Number | | |
| 2004 | PTRB | (b) (6) | 20 | 80 | TX | (b) (6) | | |
| | | | | | Trailer State | Trai <u>ler License</u> No | | |
| | | | | | TX | (b) (6) | | |

Receipt Issued by: Douglas K Levingston

CES ENVIRNANT SUS Houston, TX Dot 869392

STATE OF LOUISIANA DEPARTMENT OF TRANSPORTATION AND DEVELOPMENT CALCASIEU PARISH I-10 WEST BOUND

DATE: Mar 18 2009 TIME: 06:00:28pm

Weighment Scale 1 1: 9980 lb Weighment 2: 34600 lb Scale 2 DRIVE AXLE

Weighment 3: 31980 lb Scale 3

76560 lb TOTAL:

TARE TIME DATE

76560 lb. TOTAL:

> STATE OF LOUISIANA DEPARTMENT OF TRANSPORTATION AND DEVELOPMENT CALCASIEU PARISH I-10 WEST BOUND

TIME: 06:00:40pm DATE: Mar 18 2009

9980 lb Scale 1 34600 lb Scale 2 Weighment 1: Weighment 2: Weighment 31980 lb Scale 3 3:

DRIVER/VEHICLE EXAMINATION REPORT



Louisiana State Police MCSAP PO Box 66601 Mail Slip A32 Baton Rouge, LA 70896-6601

Phone: (225)925-3800 Fax: (225)925-3912

EMAIL: motor_carrier_safety@dps.state.la.us

Report Number: LALAOA001393 Inspection Date: 03/23/2009

Start Time: 16:22 End Time: 16:46

Inspection Level: II - Walk-Around

HM Inspection Type: Bulk

CES ENVIRONMENTAL SERVICES INC

4904 GRIGGS ROAD HOUSTON, TX 77021

USDOT#: (D) (6)

Location: SCALES

County: BOSSIER, LA

Highway: 120 E

MC/MX#: 400234

State#:

Phone#: (713)676-1460

Fax#:

Driver: MENDOZA JUAN License#:

Date of Birth:

CoDriver:

State: License#:

Placard: Yes

Date of Birth:

Shipper: CES ENVIRONMENTAL SERVICES POI

Origin: PORT ARTHUR TX Bill of Lading: 83400

Destination: PINE BLUFF AR Cargo: LIQUIDS/GASES IN TANKS

VEHICLE IDENTIFICATION

<u>Unit Type Make Year State</u>

TT PTRB 2008 TX ST STAI 2007 TX Plate#

Company # 2001

261

MilePost: 28

VIN 52,000 68,000

GVWR CVSA # CVSA Issued # OOS Sticker

Cargo Tank: 407

State: TX

BRAKE ADJUSTMENTS: No Brake Measurements Required For Level 2

VIOLATIONS: No Violations Were Discovered.

HazMat: 8 Corrosive material

Special Checks: No Data for Special Checks.

State Information:

Duty Status:: N; Troop:: G; Region:: S; Attachments (Y or N):: N; Photographs (Y or N):: N; Transponder Equipped (Y or N):: N; Oper. Auth. Verified (Y or N):: Y; DL Checked (Y or N):: Y; Driver's License Class:: A; Driver's Street Address:: (b) (6) Driver's State:: (b) Driver's Zip: (b) (6) Driver's Phone # (b) (6) Terminal Terminal Manager: BRAD; PIQ Checked (Y or N): N; ISS Checked (Y or N): Y; Specification Container:: 407; Shipping Paper #:: 83400; Shipper's Mailing Address:: 2420 S GULFWAY DRIVE; Shipper's City:: PORT ARTHUR; Shipper's State:: TX; Shipper's Zip:: 77640; First Proper HM Shipping Name:: CORROSIVE LIQUIDS TOXIC NOS; First UN/NA #:: 2922; First PG:: 1; First Quantity:: 44500 LBS;

t understand and acknowledge that the Louisiana Department of Public Safety and Corrections may notify the carrier, shipper, and/or other responsible party of this inspection and of possible and/or actual penalties for the violation(s) described above. Any responsible party will have an opportunity to request a fair and impartial hearing in accordance with the Administrative Procedure Act, for any proposed civil penalty.

Signature of Driver/Carrier: X

Date: 3-23-09

NOTE TO CARRIER:

CARRIER: If this vehicle has been identified to have SELF-ADJUSTING BRAKE VIOLATIONS: A qualified service technician needs to determine why the defective brake has excessive stroke and make the appropriate repairs. Simply re-adjusting a self-adjusting brake adjuster, or reptacing it, does not guarentee that the problem is corrected. The problem may exist in the foundation brake system. By certifying this inspection report [396.9(d)] you have indicated that this vehicle now has properly functioning self-adjusting brake adjustment system.

In accordance with FMCSR 396.9(d), the motor carrier SHALL certify that all EQUIPMENT violations noted have been corrected by the below certification. This certification must be signed and returned to the above address within 15 days following the date of inspection. A copy of this report must be retained by the carrier for 12 months from the date of inspection.

CERTIFICATION OF ACTION TAKEN: the undersigned certifies that all EQUIPMENT violations noted on this report have been corrected. Failure to certify noted repairs may result in

additional penalties.

Signature Of Motor Carrier X

Report Prepare

Badge #: 0865 Copy Received By: JUAN MENDOZA



LOUISIANA STATE POLICE MOTOR CARRIER SAFETY SECTION NOTICE TO MOTOR CARRIERS

Responsibilities of the Driver

Inspection Report: The inspection report must be delivered to the motor carrier upon arrival at the next carrier terminal or facility if arrival will occur within 24 hours; otherwise the report must be immediately mailed as required under 49 CFR Part 396.9.

Uniform Traffic Summons: The traffic summons must be paid prior to the court date listed. Court and contact information is located on the lower portion of the summons. Call the phone number listed for all inquiries about the noted violation. The Motor Carrier Unit will have NO information on fine amounts, court dates, violation adjudication, traffic schools and/or whether the violation will appear on a driving record.

Responsibilities of Motor Carriers

Out-of-service equipment violations listed on the report must be corrected prior to the vehicle being placed back in service. Other equipment violations must be corrected prior to re-dispatch of the vehicle. Reports must be returned to the Department within 15 days from the date of the report certifying that equipment repairs have been made; a faxed copy is acceptable. Failure to properly certify equipment repairs may result in monetary penalties. A copy of the inspection report must be retained at the principal place of business for 12 months from the date of inspection as required under 49 CFR Part 396.9.

Note: Reports that list only driver violations do not need to be certified or returned.

Report Disposition

The Louisiana State Police will process the inspection report and will notify Responsible Parties regarding the penalty status of the violations listed on the report and of their options to contest any violation.

What is the process of notifying the responsible parties?

The Louisiana State Police will make every effort to notify Responsible Parties as quickly as possible of the violation dispositions. However, there is no way to accurately predict a time frame for such notification. In the case of an out-of-state carrier, notification will be sent to the address provided for on the carrier's Motor Carrier Identification Report as prescribed by 49 CFR Part 390.19. In the case of an intrastate carrier, notification will be sent to the carrier address of record as determined by the Department of Public Safety and Corrections. <u>Driver violations will be mailed to the address on record with the licensing authority of the state in which the person is licensed, as required by State law. If that address is not current, drivers should immediately notify the licensing authority of the state in which the person is licensed of any change of address. Louisiana State law requires drivers to notify the Office of Motor Vehicles of a change of address with-in 10 days of the change.</u>

What happens if I receive notification and do not respond to the notification?

If a carrier or driver fails to either pay the assessed fine, or request an administrative hearing, within 45 days of issuance of the notice of violation, the violation will be considered a conviction.

For Carrier violations, if the penalty is not paid timely, the amount assessed will be posted on the office of state police's official website. The outstanding penalty amount for such responsible party shall continue to appear on the web site until all fines and fees are paid in full. The office of state police will transmit the vehicle identification number of the offending vehicle for which the notice of violation was written to the office of motor vehicles. The office of motor vehicles will not renew the registration of the offending vehicle until all fines and fees associated with the notice of violation have been paid in full.

For Driver violations, if the penalty is not paid timely, the office of state police will transmit the driver's license number to the office of motor vehicles. Thirty days after mailing its own notice, the office of motor vehicles will suspend the driver's license, which suspension will remain in effect until all fines and fees assessed in the notice of violation are paid in full together with a fifty dollar license reinstatement fee.

NO PENALTY ASSESSMENTS ARE AVAILABLE UNTIL NOTICE OF VIOLATION LETTER IS PROCESSED. THE NOTICE WILL BE MAILED WITHIN 30 DAYS FROM THE DATE OF INSPECTION.

CONTACT INFORMATION

E-mail address: motor_carrier_safety@dps.state.la.us
Phone: (225)925-3800, Fax number: (225) 925-3912
Louisiana Department of Public Safety and Corrections
Office of State Police / Motor Carrier Safety Unit
Post Office Box 66601 Mail Slip A-32

| TX09200EGI02 | | TXDPS COMMERCIAL VEHICLE ENFORCEMENT CP#: 0151818 2 | | | | |
|--|--|---|--------------------------------|---|--|--|
| ARREST TKT | ☐ 9 - 15 PASS, FOR HIRE | | | • | JF#. 0131 | |
| ☑ COM. VEH. ☐ ACCIDENT ☑ CDL | <u> </u> | SP PROG: | ☑ INTERSTATE | | ☐FIXED ☑ROADS SCALE | □ ALCH □ DS |
| - | SCHEDULE CHARTER | COUNTY: HAR | | OCCUPIED | HOUSE | SW TE |
| DATE: 04/00 Lessee/MC: | 5/2009 TIME: 8:27 AM | COUNTY: ILLIA | <u> </u> | HW1: (2) US-0059 1 | N HARRISON CO. (272 USDOT | |
| Add/City/St/Zip: | | | | | ICC/M | |
| - | CES ENVIRONMENTAL SERVICES | INC | | · | TXDOT | |
| | 4904 GRIGGS ROAD HOUSTON, T | | | | PHONE | |
| | NOAH DEAN BERRY | | RACE/S | EX: BM DOB: | (b) (6) | CARD: 3/24/09 |
| Add/City/St/Zip: | (b) (6) | | | DL #: 009 | | |
| | yes 🕅 no reason for | STOP: WARN | ☐ CITATION | | CONTRABAND LOCATE | |
| | CONSENT PC INC. TO | | | | RUGS WEAPONS | |
| TIPE OF SERVOIT | Unit TYPE | | | it Van | | |
| | | PTRB 287 | (b) (6) T | (b) (6) | 1 | i |
| V 812 | OUT 2 ST | FRUE 246 | T | <u> </u> | | |
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| JUDGE: | COU | RT: | PCT./PLACE | E: PERMIT | #: | |
| PHONE: | on/before | | ΑŢ | RG WT | ‡1 80000 GV | /WR #1 |
| ADDRESS: TX | | | | RG WT | ‡2 0 GV | 7WR #2 |
| BEAL #'S REMOVED: | DEPT. SEAL #: INS | ALLED | CVSA DECAL-TT | CVSA DECAL-ST | CVSA DECAL-ST | |
| | | | | | | |
| SHIPPING #: 835 | 97 | CONSIGNOR: | DUCCO | cc | NSIGNEE: RINECO | |
| COMMODITY: PAI | NT RELATED MATERIAL | ORIGIN: | HOUSTON | TX DE | STINATION: BENTON | AR |
| | | V? PLACARDS REQ | | r | | ED SPEED |
| | NON BULK 3 | | R | | SPEED | LIMIT |
| | 9W 🔲 | SPEC. TANK | - AX 1 AX 2 | AX 3 AX 4 AX 5 AX | 6 AX 7 AX 8 RADAR | CAL. |
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| TICKET VIOL. CITE # | | | | VIOLATIONS DISCOV | | |
| 391,45 (b) | No. Y/N DISP ACC | | SE COMPLY WITH MINERS CERTIFIC | DIRECTIONS ON BACK ATE - EXP 3/24 | SIDE OF THIS FORM | |
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| - <u></u> | | | | | | |
| | | VEHICLE/DRIV | ER OUT OF SER | VICE NOTICE | | , |
| T VEHICLE Pursuant t | o authority contained in TRC Ch | | | | uthority contained in | OOS DISPOSITIONS |
| — of Service" the ve | hicle/s with defects followed bort. No person shall remove th | y "YES" in the Ou | t of Service | TRC Chapter 644 I he | | A. Repaired at Scene / Obtained Oper. Auth. |
| applied to these vehicles or operate such vehicles until the out of service Out of Service. No motor carrier shall B. Towed/Escorted to defects have been repaired and the vehicles have been restored to safe operating permit or require driver to drive or Repair Service | | | | | | |
| condition, or prop SEE CONTINUATION SH | er operating authority has been EET TROOPER COMMENTS: | obtained. | | operate any motor ve | nicle until | D. Other U. Unknown |
| | | | | | | N. Driver OOS |
| | | | , | X SI FOUR | | |
| | | | 1 | COPY RECEIVED I | . √ | Log Book Exemption |
| NSPECTED BY: | ID/REGION, | DISTRICT/AREA | FIME COMPLETED | 7 | | |
| GRAY | 081 | 38 1 A 05 | 8:51AM | REFERRAL ID | | |
| HARGES FILED BY: | | | | BRAKES INSPECTED E | BY: | |

ANY ENTRIES IN THE VIOLATIONS' SECTION OF DRIVER'S COPY, WHERE THERE IS "YES" IN THE TICKET BOX, INDICATES CHARGES FILED AGAINST THE DRIVER. THIS WILL REQUIRE CONTACTING THE JUDGE FOR APPROPRIATE DISPOSITION.

JUDGE INFORMATION IS IN HEAVY BORDERED BOX ON DRIVER'S COPY.

PAYMENTS FOR FINES SHOULD BE SENT TO THE COURT LISTED ON THE DRIVER'S COPY. DO NOT SEND PAYMENTS TO TX DPS/MCB.

CERTIFICATION OF REPAIRMAN I CERTIFY THAT THE REQUIRED REPAIRS SHOWN IN THE "OUT OF SERVICE" COLUMN ON THE OTHER SIDE OF THIS CERTIFICATE HAVE BEEN SATISFACTORILY COMPLETED. SIGNATURE OF REPAIRMAN: NAME OF SHOP (GARAGE): REPAIR WORK COMPLETED DATE: TIME:

BEEN TAKEN TO ASSURE COMPLIANCE WITH THE MOTOR CARRIER SAFETY REGULATIONS INSOFAR AS THEY ARE APPLICABLE TO MOTOR CARRIERS AND DRIVERS.

SIGNATURE OF CARRIER OFFICIAL: TITLE: DATE:

I CERTIFY THAT ALL VIOLATIONS NOTED UPON THIS REPORT HAVE BEEN CORRECTED AND ACTION HAS

ATTENTION DRIVER:

This report must be furnished to the motor carrier whose name appears on this report.

ATTENTION DRIVER:

TRC Chapter 644, Revised Statutes, requires the Motor Carrier to execute the above certification

and return this report to: / MOTOR CARRIER BUREAU

HSE Manag

TEXAS DEPARTMENT OF PUBLIC SAFETY

PO BOX 4087

AUSTIN TX 78773-0521

IMPORTANT MESSAGES

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DRIVER/VEHICLE EXAMINATION REPORT



Louisiana State Police MCSAP PO Box 66601 Mail Slip A32 Baton Rouge, LA 70896-6601

Phone: (225)925-3800 Fax: (225)925-3912

Email: motor_carrier_safety@dps.state.la.us

Phone#: (713)676-1460

HM Inspection Type: Bulk

Start Time: 10:07

Report Number: LALABQ000548

Inspection Level: II - Walk-Around

Inspection Date: 04/09/2009

Driver: SITTIG, CHARLES B License#:(b)(6)

Date of Birth: 0

CoDriver: License#:

Date of Birth:

Shipper: CITGO PETROLEUM CORPORATION

End Time: 10:24

State:

State:

Origin: SULPHUR, LA Bill of Lading: 84260 Destination: PORT ARTHUR, TX Cargo: CHEMICALS

CES ENVIRONMENTAL SERVICES INC

4904 GRIGGS ROAD HOUSTON, TX 77021

USDOT#: 00869392

MC/MX#: 400234

State#:

Location: ROADSIDE

Highway: LA 108 E County: CALCASIEU, LA

VEHICLE IDENTIFICATION

Unit Type Make Year State TT PTRB 2001 TX 2 ST OTHR 2007 TX

Plate #

Fax#:

Company # 273 260

Name:: CORROSIVE LIQUIDS, NOS; First UN/NA #:: 1760; First PG:: II; First Quantity:: 5000 GAL;

MilePost: 23

VIN

GVWR CVSA # CVSA Issued # OOS Sticker

52,000 68 000

BRAKE ADJUSTMENTS: No Brake Measurements Required For Level 2

VIOLATIONS: No Violations Were Discovered.

HazMat: 8 Corrosive material

Placard: Yes

Cargo Tank: 407

Special Checks: No Data for Special Checks.

State Information:

Duty Status:: N; Troop:: D; Region:: R; Attachments (Y or N):: N; Photographs (Y or N):: N; Transponder Equipped (Y or N):: N; Open Auth. Verified (Y or N):: Y; RADAR #:: N; LIDAR #:: N; DL Checked (Y or N):: Y; Driver's License Class:: A: Driver's Street Address: (b) (6) Driver's City::(b) (6) Driver's State::(b) Driver's Zip:(b) (6) Driver's Phone #: Terminal Manager:: RYAN THOMAS; PIQ Checked (Y or N): Y; ISS Checked (Y or N): Y; Specification Container:: 407; Shipping Paper #:: 84260; Shipper's Mailing Address:: 4401 HWY 108; Shipper's City.: SULPHUR; Shipper's State:: LA; Shipper's Zip:: 70665; First Proper HM Shipping

Lunderstand and acknowledge that the Louisiana Department of Public Safety and Corrections may notify the carrier, shipper, and/or other responsible party of this inspection and of possible and/or actual penalties for the violation(s) described above. Any responsible party will have an opportunity to request a fair and impartial hearing in accordance with the Administrative Procedure Act, for any proposed civil panalty.

Date

Signature of Driver/Carrier: X

NOTE TO CARRIER:

CARRIER: If this vehicle has been identified to have SELF-ADJUSTING BRAKE VIOLATIONS: A qualified service technician needs to determine why the defective brake has excessive stroke and make the appropriate repairs. Simply re-adjusting a self-adjusting brake adjuster, or replacing it, does not guarentee that the problem is corrected. The problem may exist in the foundation brake system. By certifying this inspection report [396.9(d)] you have indicated that this vehicle now has properly functioning self-adjusting brake adjustment system.

In accordence with FMCSR 396.9(d), the motor carrier SHALL certify that all EQUIPMENT violations noted have been corrected by the below certification. This certification must be signed and returned to the above address within 15 days following the date of inspection. A copy of this report must be retained by the carrier for 12 months from the date of inspection.

CERTIFICATION OF ACTION TAKEN: the undersigned certifies that all EQUIPMENT violations noted on this report have been corrected. Failure to certify noted repairs may result in

additional penalties.

Signature Of Motor Carrier X

Report Prepared By:

LAFLEUR S

Badge #.

Copy Received By: **CHARLES SITTIG**



******* -IND. XMT Journal- ********* Date APR-20-2009 **** Time 09:05 ******

Date/Time = APR-20-2009 09:04

Journal No. = 178

Comm. Result = OK

Page(s)

= 001/001

Duration

= 00:00:29

File No.

= 854

Mode

= Memory Transmission

Destination = 12259253912

Received ID = / 2259253912

Resolution = Fine

-CES ENVIROMENTAL -

***** DP-C264 *******************

_ **** _

7137488664- *******

| TX09319DGT01 HOUSTON POLICE E | EPARTMENT LEVEL |
|---|--|
| | CP#: 0151818 2 |
| ☐ ARREST TKT ☐ 9 - 15 PASS. FOR HIRE ☐ COM. VEH. ☐ 16 PASS. FOR HIRE | CONSTRUCTION ZONE ☐FIXED ☑ROADSIDE |
| ACCIDENT 16 PASS. NOT FOR HIRE SP PROG: | |
| ☐ CDL ☐ SCHEDULE ☐ CHARTER ☐ INTRAST | |
| DATE: 05/06/2009 TIME: 2:30PM COUNTY: HARRIS | HWY: (1) IH-0610 IN HARRIS CO. (0-37) MP#: 29 |
| Lessee/MC: CES ENVIRONMENTAL SERVICES INC | USDOT#: 869392 |
| Add/City/st/Zip: 4904 GRIGGS ROAD HOUSTON, TX 77021 | ICC/MC#: 400234 |
| OWNER: CES ENVIRONMENTAL SERVICES INC | TXDOT#: 005516524C |
| ADD/CITY/ST/ZIP:4904 GRIGGS ROAD HOUSTON, TX 77021 | PHONE#: 7136761460 |
| Operator: DONALD WILLIAM BOZEMAN RACE | :/SEX: WM DOB: (b) (6) MED CARD: 05/27/2009 |
| Add/City/St/Zip: (b) (6) | DL #: (b) (6) ST: TX DL CLASS: A |
| VEH SEARCH: ☐ YES ☑ NO REASON FOR STOP: ☐WARN ☐CITAT: | ONINSPECTION CONTRABAND LOCATED:YES |
| TYPE OF SEARCH: CONSENT DPC INC. TO ARREST INVENTORY TYPE | of contraband: |
| Unit TYPE#MAKE CO# DEPLETE | Stat VIN |
| 1 TT PTRB 291 (b) (6) | TX |
| Y Moveldingenian 2 ST ACRO 233 | TX AND AND AND AND AND AND AND AND AND AND |
| V | |
| SIGNATURE: | |
| I HEREBY PROMISE TO APPEAR AT THE TIME AND PLACE DESIGNATED IN THIS NOTICE. (THIS IS NOT A PLEA OF GUILTY) | |
| ☑ COPY RECEIVED BY GROSS WEIGHT: | GROUP WEIGHT: |
| YOU ARE HEREBY NOTIFIED TO APPEAR | LOAD DISP: |
| JUDGE: COURT: PCT./PI | ACE: PERMIT #: |
| PHONE: ON/BEFORE AT | RG WT #1 80,000 GVWR #1 |
| ADDRESS: TX | RG WT #2 00000 GVWR #2 |
| SEAL #'S REMOVED: DEPT. SEAL #; INSTALLED CVSA DECAL-T | T CVSA DECAL-ST CVSA DECAL-ST |
| | |
| SHIPPING #: 85741 CONSIGNOR: CES | CONSIGNEE: KMTEX |
| | |
| COMMODITY: CHEMICALS ORIGIN: HOUSTON | TX DESTINATION: PORT AUTHUR TX RILEGED SPEED |
| BULK 3 D P | SPEED LIMIT |
| | 2 AX 3 AX 4 AX 5 AX 6 AX 7 AX 8 RADAR CAL. |
| 312 _L | |
| TICKET VIOL. CITE # Unit OOS OOS POST | VIOLATIONS DISCOVERED |
| 1 | TH DIRECTIONS ON BACK SIDE OF THIS FORM |
| 393.60(C) 1 DAMAGED/DISCOLORED WINDSHIELD - | CRACKED DRIVER SIDE |
| | |
| | |
| | |
| | |
| | |
| | |
| VEHICLE/DRIVER OUT OF S | ERVICE NOTICE |
| VEHICLE Pursuant to authority contained in TRC Chapter 644 I hereby declare "Out of Service" the vehicle/s with defects followed by "YES" in the Out of Service | DRIVER Pursuant to authority contained in OOS DISPOSITIONS TRC Chapter 644 I hereby notify and A. Repaired at Scene / |
| column of this report. No person shall remove the out of service stickers applied to these vehicles or operate such vehicles until the out of service | declare the driver named on this report Obtained Oper, Auth. Out of Service. No motor carrier shall B. Towed/Escorted to |
| defects have been repaired and the vehicles have been restored to safe operating condition, or proper operating authority has been obtained. | permit or require driver to drive or operate any motor vehicle until D. Other |
| SEE CONTINUATION SHEET TROOPER COMMENTS: | U. Unknown N. Driver 00S |
| D & A = YES (DRIVER WAS ADVISED OF LISTED VIOLATIONS) | |
| | X Toyald Royanan |
| | COPY RECEIVED BY |
| INSPECTED BY: ID/REGION/DISTRICT/AREA TIME COMPLE | TED REPORT PREPARED BY: MIRELES, SEBASTIAN D. |
| MIRELES, SERASTIAN D. 2V-082226 2 9 V 3:10PM CHARGES FILED BY: | REFERRAL ID |
| PORROGEO DILLED BI: | BRAKES INSPECTED BY: |

ANY ENTRIES IN THE VIOLATIONS' SECTION OF DRIVER'S COPY, WHERE THERE IS "YES" IN THE TICKET BOX, INDICATES CHARGES FILED AGAINST THE DRIVER. THIS WILL REQUIRE CONTACTING THE JUDGE FOR APPROPRIATE DISPOSITION.

JUDGE INFORMATION IS IN HEAVY BORDERED BOX ON DRIVER'S COPY.

PAYMENTS FOR FINES SHOULD BE SENT TO THE COURT LISTED ON THE DRIVERS COPY. DO NOT SEND PAYMENTS TO TX DPS/MCB.

CERTIFICATION OF REPAIRMAN

I CERTIFY THAT THE REQUIRED REPAIRS SHOWN IN THE "OUT OF SERVICE" COLUMN ON THE OTHER SIDE OF THIS CERTIFICATE HAVE BEEN SATISFACTORILY COMPLETED.

SIGNATURE OF REPAIRMAN:

NAME OF SHOP (GARAGE):

REPAIR WORK COMPLETED

PES ENU.

DATE: 5-8-09

MOTOR CARRIER CERTIFICATION OF ACTION TAKEN

CERTIFY THAT ALL VIOLATIONS NOTED UPON THIS REPORT HAVE BEEN CORRECTED AND ACTION HAS BEEN TAKEN TO ASSURE COMPLIANCE WITH THE MOTOR CARRIER SAFETY REGULATIONS INSOFAR AS THEY ARE APPLICABLE TO MOTOR CARRIERS AND DRIVERS.

SIGNATURE OF CARRIER OFFICAL:

TITLE:

DATE:

luy

ATTENTION DRIVER:

This report must be furnished to the motor carrier whose name appears on this report.

ATTENTION DRIVER:

TRC Chapter 644, Revised Statutes, requires the Motor Carrier to execute the above certification

and return this report to: MOTOR CARRIER BUREAU

TEXAS DEPARTMENT OF PUBLIC SAFETY

PO BOX 4087

AUSTIN TX 78773-0521

IMPORTANT MESSAGES

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| TX09489DBB01 | HARRIS CC | UNTY SHERIFF | SOFFICE | 3D# 01F1 | LEVEL |
|--|--|--|--|--|---|
| ARREST TKT 9 - 15 PASS. | FOR HIRE | | (| CP#:0151 | .818 2 |
| COM. VEH. 16 PASS. FOR | HIRE | co | NSTRUCTION ZONE | ☐FIXED ☑ ROADS | IDE |
| 177 apr | FOR HIRE SP PROG: | | YES M NO | SCALE | ALCH DS |
| | | | OCCUPIED | HOUSE | SW _ TE |
| DATE: 06/01/2009 TIME: Lessee/MC: CES ENVIRONMENTAL | 6:00 AM COUNTY: HARRIS | , , , , , , , , , , , , , , , , , , , | WY: (2) US-0059 I | N HARRIS CO. (492-5 | |
| Ecosec inc. | HOUSTON, TX 77021 | | | USDOT | |
| OWNER: STEVEN K STRICKER | | | | ICC/M | |
| ADD/CITY/ST/ZIP:(b) (6) | | | | TXDOT | |
| Operator: ROLANDO MORALES | | RACE/SEX | um pon. | (b) (6) | |
| | | RACE/SEX | : HM DOB: DL #: (b) | (6) MED C | |
| Add/City/St/Zip: (b) (6) | · · · | —————————————————————————————————————— | | ST: | |
| | REASON FOR STOP: WARN | CITATION | INSPECTION | CONTRABAND LOCATED | |
| TYPE OF SEARCH: CONSENT PC | ☐ INC. TO ARREST ☐ INVENT | | | RUGS WEAPONS | CURRENCY DTHER |
| | 1 TT PTRB 298 | (b) (6) TX | VIN | أبستنشف | |
| 1 A A A | 2 ST FRUE 245 | TX | | | |
| 1 X 1 t $_{0}$ V $_{1}$ U $_{1}$ U $_{2}$ | | | | | |
| SIGNATURE: | 100 | | | #4 ## ## ############################# | 1917 - 1917 - 1917 - 1917 - 1917 - 1917 - 1917 - 1917 - 1917 - 1917 - 1917 - 1917 - 1917 - 1917 - 1917 - 1917 |
| I HEREBY PROMISE TO APPEAR AT TH | E TIME AND | | | | |
| PLACE DESIGNATED IN THIS NOTICE NOT A PLEA OF GUILTY) | (MUTO 70 | , 00 |) | | |
| , | GROSS WEIGHT: | O L'Asset | CROUD | WEIGHT: | |
| COPY RECEIVED BY | GKOSS WEIGHT: | · | | | |
| YOU ARE HEREBY NOTIFIED TO APPEAR | COMPIN | DCS: (D) ACE: | LOAD DI | ISP: | |
| JUDGE: | COURT: | PCT./PLACE: | PERMIT | 002000000 | |
| PHONE: ON/BE | FORE | ΑT | | | WR #1 |
| ADDRESS: TX | | | RG WT # | | WR #2 |
| SEAL #'S REMOVED: DEPT. SI | CV #; INSTALLED CV | SA DECAL-TT | CVSA DECAL-ST | CVSA DECAL-ST | |
| | | | l | <u> </u> | |
| SHIPPING #: 005596937JJK | CONSIGNOR: L | UBRIZOL | co | NSIGNEE: RINECO | |
| COMMODITY: FLAM LIQUID/CORRO | SIVES ORIGIN: D | EER PARK | TX DE | STINATION: BENTON | AR |
| HM CATEGORY COD | E RQ? HW? PLACARDS REQ? | 1 1 4 4 | | | ED SPEED |
| OTHER BULK 3 | | R | | SPEED | LIMIT |
| | SPEC. TANK | AX 1 AX 2 A | 3 AX 4 AX 5 AX | 6 AX 7 AX 8 RADAR | CAL. |
| | TPT | L | | | |
| | POST | | TOLATIONS DISCOV | | |
| No. Y/N DISE | ACC DRIVER: PLEASE | COMPLY WITH DI | RECTIONS ON BACK | SIDE OF THIS FORM | |
| | , and the second | The second secon | | The transfer of the second to be a record, white second to the second to | |
| | | | | | |
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| | | · | | | |
| | VEHICLE/DRIVER | OUT OF SERVI | OF NOTICE | | |
| VEHICLE Pursuant to authority contain | · · | | | authority contained in | OOS DISPOSITIONS |
| of Service" the vehicle/s with defect column of this report. No person sha | s rollowed by "YES" in the out | or Service | TRC Chapter 644 I he | ereby notify and named on this report | A. Repaired at Scene / Obtained Oper. Auth. |
| applied to these vehicles or operate defects have been repaired and the ve | such vehicles until the out of hicles have been restored to sa | service fe operating | Out of Service. No m permit or require dr | motor carrier shall river to drive or | B. Towed/Escorted to Repair Service |
| condition, or proper operating author | ity has been obtained. COMMENTS: | | operate any motor ve | | D. Other U. Unknown |
| 13300 EASTEX NB VIN- | G TESTING - Y | | | | N. Driver OOS |
| | | \ \ | • | | |
| | | | CODY DECESTORS | nu . | Log Book Exemption |
| INSPECTED BY: | ID/REGION/DISTRICT/AREA T | IME COMPLETED R | COPY RECEIVED I | | |
| GRAWEY, JOHN A | 2S-014102 2 9 S | 6:30AM | REFERRAL ID | | |
| CHARGES FILED BY: | | (B | RAKES INSPECTED A | BY: | |

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SIGNATURE OF REPAIRMAN:

NAME OF SHOP (GARAGE):

REPAIR WORK COMPLETED: TIME:

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SIGNATUREOF CARRIER OFFICIAL:

TITLE:

DATE:

6-2-09

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ATTENTION DRIVER: ATTENTION DRIVER:

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MOTOR CARRIER SAFETY SECTION TEXAS DEPARTMENT OF PUBLIC SAFETY

PO BOX 4087

AUSTIN TX 78773-0521

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PB-019C-(08/05)

| ISECX245498600003 | | | CVE- | -3 (Rev. 12/03) |
|--|---|---|---|--|
| TX094A0ECX03 | TXDPS COMMERCIAL VEHIC | LE ENFORCEMENT | CP#: 01518 | 10 LEVEL |
| ☐ ARREST TKT ☐ 9 - 15 PASS. FOR HIRE ☐ COM. VEH. ☐ 16 PASS. FOR EIRE ☐ ACCIDENT ☐ 16 PASS. NOT FOR HIRE | SP PROG: ☑ INTERSTA | CONSTRUCTION ZONE | P#: UI318. □FIXED ☑ROADSIDE | ALCH DS |
| ☐ ACCIDENT ☐ TO FASS. NOT FOR RIVE | RDCHCK INTRASTA | T IF2 KN NO | SCALE HOUSE | SW TE |
| DATE: 06/03/2009 TIME: 7:39 AN | 1 COUNTY: CHAMBERS | HWY: (1) IH-0010 II | N CHAMBERS CO. (797-831 |) MP#: 817 |
| Add/City/St/Zip: | | | USDOT#: | 869392 400234 |
| OWNER: CES ENVIRONMENTAL SERVICES | G INC | | TXDOT#: | 005516524C |
| ADD/CITY/ST/ZIP:4904 GRIGGS ROAD HOUSTON, | TX 77021 | | PHONE#: | 7136761460 |
| Operator: DONALD WILLIAM BOZEMAN | RACE | /SEX: WM DOB: | h) (C) | 06/12/2009 |
| Add/City/St/2ip: (b) (6) | | DL #: (b) (| ST: TX | DL CLASS: A |
| VEH SEARCH: YES NO REASON FO | R STOP: WARN CITATI | ONINSPECTION | CONTRABAND LOCATED: | _Yes √ no |
| TYPE OF SEARCH: CONSENT PC INC. 1 | | | rugs weapons curr | ENCY OTHER |
| Control of the Contro | | stat VIN TX <mark>(b) (6)</mark> TX | | |
| SIGNATURE: | | | #[1 10 # | <u> </u> |
| I HEREBY PROMISE TO APPEAR AT THE TIME A PLACE DESIGNATED IN THIS NOTICE. (THIS I NOT A PLEA OF GUILTY) | | 00 | 00 | |
| ☑ CODA BECEIARD BA | GROSS WEIGHT: | GROUP | WEIGHT: | |
| YOU ARE HEREBY NOTIFIED TO APPEAR | | LOAD DI | SP: | |
| JUDGE: CC | OURT: PCT,/FL | ACE: PERMIT | #: | |
| PHONE: ON/BEFORE | AT | RG WT # | 1 80000 GVWR + | F1 ; |
| ADDRESS: TX | | RG WT # | 2 14700 GVWR # | 2 |
| SEAT, #'S REMOVED: DEFT. SEAL #; IN | STALLED CVSA DECAL-TI | CVSA DECAL-ST | CVSA DECAL-ST | |
| | | | <u> </u> | |
| SHIPPING #: 87015 | CONSIGNOR: CES ENVIRO | MENTAL CON | ISIGNEE: NEWPARK | |
| COMMODITY: WASTE WATER | ORIGIN: HOUSTON | TX DES | TINATION: WINNIE | TX |
| | HW? PLACARDS REQ? R | | ALLEGED SI | |
| NA . | SPEC. TANK AX 1 AX | 2 AX 3 AX 4 AX 5 AX | 6 AX 7 AX 8 RADAR CAL | |
| | 407 L | | | • |
| TICKET VIOL. CITE # Unit OOS OOS POST | | VIOLATIONS DISCOV | | |
| No. Y/N DISP ACC REQ | DRIVER: PLEASE COMPLY WIT UIRED INFORMATION NOT SHOWN O | | SIDE OF THIS FORM | |
| | E LESS THAN 2/32 OF AN INCH - | R/S 2ND AXLE O/S | | |
| | | | | |
| | | | | |
| | | DVICE NOTICE | | |
| VEHICLE Pursuant to authority contained in TRC | | | | |
| | VEHICLE/DRIVER OUT OF SE | | uthority contained in COS | DISPOSITIONS |
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JUDGE INFORMATION IS IN HEAVY BORDERED BOX ON DRIVER'S COPY.

PAYMENTS FOR FINES SHOULD BE SENT TO THE COURT LISTED ON THE DRIVER'S COPY.

DO NOT SEND PAYMENTS TO TX DPS/MCB.

CERTIFICATION OF REPAIRMAN

I CERTIFY THAT THE REQUIRED REPAIRS SHOWN IN THE "OUT OF SERVICE" COLUMN ON THE OTHER SIDE OF THIS CERTIFICATE HAVE BEEN SATISFACTORILY COMPLETED.

SIGNATURE OF BEPAIRMAN:

NAME OF SHOP (GARAGE):

REPAIR WORK COMPLETED

PES ENV.

DATE:

TIME: / 4,20

MOTOR CARRIER CERTIFICATION OF ACTION TAKEN

I CERTIFY THAT ALL VIOLATIONS NOTED UPON THIS REPORT HAVE BEEN CORRECTED AND ACTION HAS BEEN TAKEN TO ASSURE COMPLIANCE WITH THE MOTOR CARRIER SAFETY REGULATIONS INSOFAR AS THEY ARE APPLICABLE TO MOTOR CARRIERS AND DRIVERS.

SIGNATURE OF CARRIER OFFICIAL:

TITLE:

DATE:

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6.3.09

ATTENTION DRIVER:

This report must be furnished to the motor carrier whose name appears on this report.

ATTENTION DRIVER:

TRC Chapter 644. Revised Statutes, requires the Motor Carrier to execute the above certification

and return this report to: MOTOR CARRIER BUREAU

TEXAS DEPARTMENT OF PUBLIC SAFETY

PO BOX 4087

AUSTIN TX 78773-0521

IMPORTANT MESSAGES

Any enforcement actions taken against you and any subsequent court actions are intended to secure compliance with the traffic laws and all other users of the highways. Failure to comply with your written promise to appear in court as made on this citation will constitute a separate offense with which you may be charged and result in warrants being issued for your arrest. Failure to appear in court or failure to satisfy a judgement ordering payment of a fine and cost in the manner ordered by the court may result in the denial of renewal of your driver's license.

"A second or subsequent conviction of failure to maintain financial responsibility will result in the suspension of your driver license and motor vehicle registration unless you file and maintain proof of financial responsibility with the Department of Public Safety for two (2) years from the date of conviction. The Department may waive the requirements to file proof of financial responsibility if you file satisfactory evidence with the Department showing that at the time this citation was issued the vehicle was covered by a liability insurance policy or that you were otherwise exempt from the requirements to provide evidence of financial responsibility.

You may be able to require that this charge be dismissed by successfully completing a driving safety course or a motorcycle operator training course. You will lose that right if, on or before your appearance date, you do not provide the court with notice of your request to take the course. This article does not apply to an offense committed by a person who holds a commercial driver's license.

"A conviction of an offense under a traffic law of this state or a political subdivision of this state may result in the assessment on your driver's license of a surcharge under the Driver Responsibility Program."

A request for an out-of-service review, regarding operating authority, must be made in writing and forwarded to the manager of the Motor Carrier Bureau. If requested, a review will be scheduled and conducted by the manager of the Motor Carrier Bureau or the director's designee within 10 days of the issuance of the out-of-service order. A request for review should be addressed to the Texas Department of Public Safety, Motor Carrier Bureau, P.O. Box 4087, Austin, TX 78773-0521 or may be sent by facsimile transmission to (512) 424-5712 or via electronic mail at MotorCarrierBureau@txdps.state.tx.us.. The Department may conduct the review by telephone conference call.

To obtain a TxDOT Motor Carrier Insurance Certificate or Single State Registration - contact the Texas Department of Transportation at 1-800-299-1700 or visit their website at www.dot.state.tx.us.

To obtain a USDOT Number contact the Federal Motor Carrier Safety Administration at 1-800-832-5660 or visit their website at www.fmcsa.dot.gov/factsfigs/formspubs.htm.

To obtain IFTA information contact the State of Texas Comptrollers Office at 1-800-252-1383 or visit their website at www.window.state.tx.us/taxinfo/fuels/ifta.html.

attn: Colleen

Joyn need more from me please (b) (6)

Shanks Dennette Sartin

Called 6-17-09 9:29am Will call back

6-19-09-11:48 AM
COllen Called & told
me its diamissed because
we provided current cab
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IMPORTANT MESSAGES

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TEXAS APPORTIONED LICENSE CAB CARD

Expires: May 31, 2010

CES ENVIRONMENTAL SERVICES INC

4904 GRIGGS RD HOUSTON, TX 77021 Reg Year: Acct:

2009 50369 Region: County:

Control:

HO 101

Fleet:

1

9008-2766-6008

Reg Date: 06/01/2009

| Plate | Type | Unit Number | Unladen Wgt | Gross Wgt | Axles | Seats |
|------------|-----------|-------------|-------------|-----------|---------------|----------------|
| (b) (6) | TT, | 2001 | 17500 | 80000 | 3 | 0 |
| Model Year | Make | Fuel | Docum | nent# | (b) (c) | N |
| 2008 | PTRB | Ď | 101754392 | 93151210 | (D) (O) | |
| : | T. 135.5. | 277.AF 48 | | | The Section 1 | 40. % 10. % |

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| co | 80000 80000 | MS NC | 80000 80000 80000 | VA WI | 80000 80000 80000 | e T | | 1.00 to 1.00 t | | | |
| GA IL | 80000 80000 | | 80000 80000 80000 | ** | 80000 | | | | | | |
| KS KY | 80000 80000 80000 | OH | 80000 80000 80000 | | | | | | | | |

This apportioned cab card must be carried in the vehicle at all times

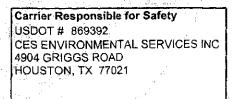
Only one plate issued for a power unit and it must be displayed on front of the vehicle. A windshield or plate validation sticker is not required or issued with this registration receipt.

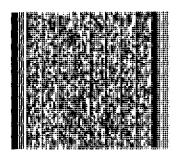
The face of this cab card lists those jurisdictions in which the vehicle described is proportionally registered together with the registered gross weight. At the end of the listing a series of asterisks will appear in the following block. No jurisdictions are to be listed after the block containing these asterisks. Otherwise the cab card is invalid.

Notice of Federal Motor Carrier safety regulations and materials regulations for owners of the following listed vehicles:

- *Vehicles weighing in excess of 10,000 lbs.
- *Farm vehicles weighing in excess of 10,000 lbs.
- *Vehicles transporting 15 or more passengers
- *Vehicles transporting hazardous materials requiring a placard

Payment of required registration fees is a declaration of knowledge that Texas has adopted and enforces the Federal Motor Carrier safety regulations and hazardous material regulations, and it is the obligation of the registrant to be familiar with the applicable requirements.





If this vehicle is sold or otherwise deleted from your fleet, this cab card and corresponding license plate must be surrendered to the Texas Department of Transportation.

THE STATE OF TEXAS GRANTS A GRACE PERIOD OF FIVE (5) WORKING DAYS AFTER EXPIRATION

Register online at https://irp.dot.state.tx.us

| TREEL TADPS COMMERCIAL VEHICLE ENFORCEMENT |
|--|
| DATE:2009-06-10 10:18 4 |
| TX094H0EDK04 |
| CP#0151818 ISEDK245499300004 |
| NET: (2) US-0069 IN JEFFERSON CO. (514-544) HF#: 535 WHIGH CES ENVIRONMENTAL SERVICES INC |
| Add::4904 GRIGGS ROAD HOUSTON, TX 77021 |
| NOTE TO MOTOR CARRIER: TRC Chapter 644 requires the Motor Carrier to execute the certification at the end and return this report to Texas Department |
| of Public Safety; Motor Carrier Safety Section, PO Box 4087, Austin, Texas .78773-0001 within fifteen (15) days. |
| FHONE#: USDOT#: ICC/MC#: TXDOT#: 7136761460 869392 400234 005516524C |
| NT# DGGD5637 cm, my cm, co, a |
| OPERATOR: WILSON REVIN LYNN Address: (b) (6) RAFE/SER: WM GOE: (b) (6) MED CARD: 10-03-10 |
| NOTE TO DRIVER. This report must be furnished to the motor carrier whose name appears on this report. |
| ☑ CDL CONSTRUCTION SOME ☐ ALCH ☐ DS ☐ ACCIDENT ☐ YES ☑ No (☐ GOLUFIED ☐ SW ☐ TE |
| UNITITYPE MAKE CO# PLATE ST VIN |
| 1 TT FTRE 2001 R88017 TX IXPWDB9X08D751225 |
| Axles:X 00 |
| RG WT #1 80000 ESVWE #1 |
| VIOLATIONS DISCOVERED |
| TICRET VIOL CITE # Hear# COS POST DISP ACT |
| Yes 1 |
| DISPLAY EXPIRED LICENSE PLATE (#) - 5-2009 |
| BISP'SITIONS B. Rowed/Exported to Repair Service D. Other - N. Drive: S |
| SEAL # S REMOVED: DRFT. SEAL #; INSTALLED |
| Shipping#: |
| Connectity EMPTY Grigin: BEAUMONT, TX |
| Dest: PORT ARTHUR, TX THEODORY TO BE. BEEKEGION/DISTRICT/AREA |
| THEPDOTED BY: K SANDERS 08561 2 A 05 |
| YOU ARE HEREBY NOTIFIED TO APPEAR BEFORE |
| CORRECT: JP FOR AT 10:00:00% |
| FHONE: (409) 835-8522 ON/DEPORE Tuesday, 30 June, 2009 ADDRESS: 1001 PEARL ST BEAUMONT TX 77701 |
| I HEREPY PERMISE TO APPEAR AT THE TIME AND PLACE DESIGNATED |
| IN THIS MedicE. (This is not a plea of guilty) |
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| X Soules (July) |
| 1 July as well |
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IMPORTANT MESSAGES

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POTENTIAL SURCHARGE NOTICE:

"A conviction of an offense under a traffic law of this state or a political subdivision of this state may result in the assessment on your driver's license of a surcharge under

A request for an out-of-service review, regarding operating authority, must be made in writing and forwarded to the manager of the Motor Carrier Bureau. If requested, a review will be scheduled and conducted by the manager of the Motor Carrier Bureau or the director's designee within 10 days of the issuance of the out-of-service order. A request for review should be addressed to the Texas Department of Public Safety, Motor Carrier Bureau, P.O. Box 4087, Austin, TX 78773-0521 or may be sent by facsimile transmission to electronic mail (512)424-5712 or via MotorCarrierBureau@txdps.state.tx.us. The Department may conduct the review by telephone conference call.

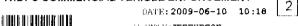
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To obtain !FTA information contact the State of Texas Comptrollers Office at 1-800-252-1383 or visit their website www.window.state.tx.us/taxinfo/fuels/ifta.html.

Cut here and return the below portion to Motor Carrier Bureau, after it's been completed.

TXDPS COMMERCIAL VEHICLE ENFORCEMENT





CMR 3



ANY ENTRIES IN THE VIOLATIONS' SECTION OF DRIVER'S COPY, WHERE THERE IS "YES" IN THE TICKET BOX, INDICATES CHARGES FILED AGAINST THE DRIVER. THIS CONTACTING WILL REQUIRE THE APPROPRIATE DISPOSITION.

JUDGE: Hon. Ken Dollinger in Jefferson Co. AT 10:00:00 COURT: JP POT./FLACE: 1/1 PHONE: (409) 835-8522 OH/BEROSE Tuesday, June 30, 2009 ADDRESS: 1001 PEARL ST BEAUMONT TX 77701

CERTIFICATION OF REPAIRMAN

I CERTIFY THAT THE REQUIRED REPAIRS SHOWN IN THE "OUT OF SERVICE" COLUMN ON THIS CERTIFICATE HAVE BEEN SATISFACTORILY COMPLETED

SIGNATURE OF REPAIRMAN

NAME OF SHOP (GARAGE):

REPAIR WORK COMPLETED

DATE

TIME

Motor Carrier Certification of action taken CERTIFY THAT ALL VIOLATIONS NOTED UPON THIS REPORT HAVE BEEN CORRECTED AND ACTION HAS BEEN TAKEN TO ASSURE COMPLIANCE WITH THE MOTOR CARRIER SAFETY REGULATIONS INSOFAR AS THEY ARE APPLICABLE TO MOTOR CARRIERS AND DRIVERS.

Signature of Carrier Official:

DATE

ATTENTION DRIVER: This report must be furnished to the motor carrier whose name appears on this report.

TRC Chapter 644. Revised Statutes, requires the Motor Carrier to execute the above certification. MOTOR CARRIER BUREAU

, , and return this report to: Texas Department of Public Safety PO BOX 4087 AUSTIN TX 78773-0521

| TX09539DBV0A | HOUSTON POLICE DEPARTMENT | CP#: 0151818 2 |
|--|---|---|
| ARREST TKT 9 - 15 PASS. FOR HIRE COM. VEH. 16 PASS. FOR HIRE ACCIDENT 16 PASS. NOT FOR HIRE SP CDL SCHEDULE CHARTER | PROG: INTERSTATE YES INTERSTATE COCCUPIED | ZONE FIXED MROADSIDE ALCH DS |
| DATE: 07/02/2009 TIME: 8:15 | 5PM COUNTY: HARRIS HWY: | 1) IH-0610 IN HARRIS CO. (0-3' M.P.#: 29 |
| LESSEE/MC: CES ENVIRONMENTAL SERVICES INC | | USDOT#: 0869392 |
| ADD/CITY/ST/ZIP: 4904 GRIGGS ROAD HOUSTON TX | 77021 | ICC/MC#: 400234 |
| OWNER: STEVEN K STRICKER | | TXDOT#: 005516524C |
| ADD/CITY/ST/ZIP: (b) (6) | | PHONE#: 7136761460 |
| OPERATOR: JUAN MIGUEL FRIAS | RACE/SEX: HM DO | (la) (C) |
| (b) (6) | | (b) (c) |
| | DL #: | |
| VEH SEARCH: ☐ YES ☑ NO REASON FOR STO | P: WARN CITATION INSPECT | ON CONTRABAND LOCATED: YES NO |
| TYPE OF SEARCH: CONSENT PC INC. TO ARR | REST INVENTORY TYPE OF CONTRABAND: | ☐ DRUGS ☐ WEAPONS ☐ CURRENCY ☐ OTHER |
| X SIGNATURE: | UNIT TYPE MAKE CO# PU 1 TT PTRB 2003 (b) (6 | 0 2000 |
| I HEREBY PROMISE TO APPEAR AT THE TIME AND PLACE DESIGNATED IN THIS NOTICE. (THIS IS | | |
| NOT A PLEA OF GUILTY) | 00 00 | |
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| YOU ARE HEREBY NOTIFIED TO APPEAR | Lo | AD DISP: |
| JUDGE: COURT: | PCT./PLACE: | RMIT #: |
| PHONE: ON/BEFORE | | WT #1 80000 GVWR #1 |
| ADDRESS: TX | 17.3 | WT #1 00000 GVWR #1 |
| | | |
| SEAL #'S REMOVED: DEPT. SEAL #; INSTALL | ED CVSA DECAL-TT CVSA DECAL- | ST CVSA DECAL-ST |
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| SHIPPING #: | CES ENVIRONMENTAL | CONSIGNEE: CES ENVIRONMENTAL |
| COMMODITY: O | PRIGIN: HOUSTON T | X DESTINATION: HOUSTON TX |
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| | L | · |
| TICKET VIOL. CITE # Unit OOS OOS POST | VIOLATIONS D | ISCOVERED |
| | DRIVER: PLEASE COMPLY WITH DIRECTIONS ON | |
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| | | |
| | | |
| VFI | HICLE/DRIVER OUT OF SERVICE NOTICE | |
| O'EHICLE Pursuant to authority contained in TRC Chapter of Service" the vehicle/s with defects followed by "Yi column of this report. No person shall remove the outlier of these vehicles or operate such vehicles und defects have been repaired and the vehicles have been condition, or proper operating authority has been obtained by the continuation of the continuati | r 644 I hereby declare "Out ES" in the Out of Service t of service stickers til the out of service restored to safe operating | t to authority contained in 4 I hereby notify and iver named on this report 1. No motor carrier shall itre driver to drive or tor vehicle until 1. To authority contained in 0. Dispositions A. Repaired at Scene / 0btained Oper. Auth. B. Towed/Escorted to Repair Service D. Other U. Unknown N. Driver OOS |
| Weather = Clear / DRY / DUSK GOOD JOB | X COPY RECEI | ☐ Fod Book Exemption |
| INSPECTED BY: ID/REGION/DIS | TRICT/AREA TIME COMPLETED REPORT PREPAR | |
| RICHIE, CHRISTOPHER A. 2V-09393 | | |
| CHARGES FILED BY: | | |

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I CERTIFY THAT THE REQUIRED REPAIRS SHOWN IN THE "OUT OF SERVICE" COLUMN ON THE OTHER SIDE OF THIS CERTIFICATE HAVE BEEN SATISFACTORILY COMPLETED.

SIGNATURE OF REPAIRMAN: NAME OF SHOP (GARAGE):

REPAIR WORK COMPLETED

TIME:

MOTOR CARRIER CERTIFICATION OF ACTION TAKEN

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SIGNATURE OF CARRIER OFFICAL:

TITLE:

DATE:

HIE Manage

ATTENTION DRIVER:

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ATTENTION DRIVER:

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and return this report to:

MOTOR CARRIER BUREAU TEXAS DEPARTMENT OF PUBLIC SAFETY

PO BOX 4087

AUSTIN TX 78773-0521

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You may be able to require that this charge be dismissed by successfully completing a driving safety course or a motorcycle operator training course. You will lose that right if, on or before your appearance date, you do not provide the court with notice of your request to take the course. This article does not apply to an offense committed by a person who holds a commercial driver's license.

"A conviction of an offense under a traffic law of this state or a political subdivision of this state may result in the assessment on your driver's license of a surcharge under the Driver Responsibility Program."

A request for an out-of-service review, regarding operating authority, must be made in writing and forwarded to the manager of the Motor Carrier Bureau. If requested, a review will be scheduled and conducted by the manager of the Motor Carrier Bureau or the director's designee within 10 days of the issuance of the out-of-service order. A request for review should be addressed to the Texas Department of Public Safety, Motor Carrier Bureau, P.O. Box 4087, Austin, TX 78773-0521 or may be sent by facsimile transmission to (512)424-5712 or via electronic mail at <u>MotorCarrierBureau@txdps.state.tx.us</u>. The Department may conduct the review by telephone

To obtain a TXDOT Motor Carrier Insurance Certificate or Single State Registration - contact the Texas Department of Transportation at 1-800-299-1700 or visit their website at www.dot.state.tx.us.

To obtain a USDOT Number contact the Federal Motor Carrier Safety Administration at 1-800-832-5660 or visit their website at www.fmcsa.dot.gov/factsfigs/formspubs.htm.

To obtain IFTA information contact the State of Texas Comptrollers Office at 1-800-252-1383 or visit their website at www.window.state.tx.us/taxinfo/fuels/ifta.html.

| IS9DCM245502000001 | | | CVE-3 (Rev. 12/03) |
|---|---|---|--|
| TX09589DCM01 | HOUSTON POLICE DEP | CP#: 015 | LEVEL |
| ARREST TKT 9 - 15 PASS. FOR HI | IRE | CP#: 015. | 1919 2 |
| ☑ COM. VEH. ☐ 16 PASS. FOR HIRE | | CONSTRUCTION ZONE FIXED PROADS | SIDE C NO. C PS |
| ☐ ACCIDENT ☐ 16 PASS. NOT FOR HI | <u> </u> | LIES V NO SCALE | ALCH DS |
| ☑ CDL ☐ SCHEDULE ☐ CHART | | | SW TE |
| DATE: 07/07/2009 TIME: 7:21 | AM COUNTY: HARRIS | HWY: (1) IH-0010 IN HARRIS CO. (742- | |
| Lessee/MC: | | USDO' | I#: 869392 |
| Add/City/St/Zip: | | ICC/I | MC#: 400234 |
| OWNER: CES ENVIRONMENTAL SERVI | CES INC | TXDO | T#: 005516524C |
| ADD/CITY/ST/ZIP: 4904 GRIGGS ROAD HOUSTO | N, TX 77021 | PHON | E#: 7136761460 |
| Operator: DONALD WILLIAM BOZEMAN | RACE/S | EX: WM DOB: (b) (6) MED | CARD: 06/10/2010 |
| Add/City/St/Zip: (b) (6) | | DL #: (b) (6) ST: | TX DL CLASS: A |
| | FOR STOP: WARN CITATION | INSPECTION CONTRABAND LOCATE | D: TYES MO |
| | | of contraband: Drugs Weapons | |
| | C. TO ARREST ☐ INVENTORY TYPE OF STREET STREETS STREE | | CORRENCT DOTRER |
| 1 | TT PTRB 291 (b) (6) T | | |
| - Reald/Spane | alkanari | III 45 iS M1245 11 | |
| X Sonal dB szunan | | | |
| SIGNATURE: | | 111 18 18 18 18 18 18 | M 00 B 0 16 16 1 0 1 PAUL 1 01 AU 15 B 1 B 1 B 1 M |
| I HEREBY PROMISE TO APPEAR AT | | | |
| THE TIME AND PLACE DESIGNATED IN THIS NOTICE. (THIS IS NOT | | x 00 | |
| A PLEA OF GUILTY) | | | |
| ☑ COPY RECEIVED BY | GROSS WEIGHT: | GROUP WEIGHT: | |
| YOU ARE HEREBY NOTIFIED TO APPEAR | | LOAD DISP: | |
| JUDGE: | COURT: PCT./PLAC | E: PERMIT #: | |
| PHONE: ON/BEFORE | AT | RG WT #1 G | VWR #1 |
| ADDRESS: TX | | RG WT #2 G | VWR #2 |
| SEAL #'S REMOVED: DEPT. SEAL #; | INSTALLED CVSA DECAL-TT | CVSA DECAL-ST CVSA DECAL-ST | |
| | | | |
| SHIPPING #: | CONSIGNOR: CES ENVIRONM | ENTAL SERVICES CONSIGNEE: CES EN | VIRONMENTAL |
| | | SERVIC | |
| COMMODITY: EMPTY | ORIGIN: HOUSTON | TX DESTINATION: HOUSTO | N TX |
| | ?? HW? PLACARDS REQ? | ALLE | GED SPEED |
| NA | | | D LIMIT |
| | SPEC. TANK AX 1 AX 2 | AX 3 AX 4 AX 5 AX 6 AX 7 AX 8 RADA | R CAL. |
| | 1 | | |
| TICKET VIOL. CITE # Unit OOS OOS POST No. Y/N DISP ACC | | VIOLATIONS DISCOVERED | |
| No. 17th Dist Acc | DRIVER:PLEASE COMPLY WITH | DIRECTIONS ON BACK SIDE OF THIS FORM | |
| | | | The state of the s |
| | | | |
| | | • | |
| | | | |
| | · | | |
| | | | |
| | | | |
| | VEHICLE/DRIVER OUT OF SEE | RVICE NOTICE | |
| VEHICLE Pursuant to authority contained in i | CPC Chantar 644 I Narahy declars "Out | DRIVER Pursuant to authority contained in | loos dispositions |
| of Service" the vehicle/s with defects follo column of this report. No person shall remo | | DRIVER Pursuant to authority contained in TRC Chapter 644 I hereby notify and declare the driver named on this report | A. Repaired at Scene / Obtained Oper. Auth. |
| applied to these vehicles or operate such ve defects have been repaired and the vehicles | ehicles until the out of service | Out of Service. No motor carrier shall permit or require driver to drive or | B. Towed/Escorted to Repair Service |
| condition, or proper operating authority has | s been obtained. | operate any motor vehicle until | D. Other |
| SEE CONTINUATION SHEET TROOPER COMME D4A=YES, UNIT#1: (b) (6) NO VIOLATIONS | NID. | | N. Driver COS |
| VEH INSPECTED IN HEAVY RAIN | Ì | V h 146 | ĺ |
| | | X doublingue | Log Book Exemption |
| | | COPY RECEIVED BY | |
| ! | | REPORT PREPARED BY: ROACH, KYLE JE | FFREY |
| ROACH, KYLE JEFFREY 2 CHARGES FILED BY: | 2V-110462 2 9 V 8:00AM | REFERRAL ID BRAKES INSPECTED BY: | · |
| CHARGE LAND DI. | | promote pro- | |

ANY ENTRIES IN THE VIOLATIONS' SECTION OF DRIVER'S COPY, WHERE THERE IS "YES" IN THE TICKET BOX, INDICATES CHARGES FILED AGAINST THE DRIVER THIS WILL REQUIRE CONTACTING THE JUDGE FOR APPROPRIATE DISPOSITION

JUDGE INFORMATION IS IN HEAVY BORDERED BOX ON DRIVER'S COPY

PAYMENTS FOR FINES SHOULD BE SENT TO THE COURT LISTED ON THE DRIVERS COPY.

DO NOT SEND PAYMENTS TO TX DPS/MCB.

CERTIFICATION OF REPAIRMAN

I CERTIFY THAT THE REQUIRED REPAIRS SHOWN IN THE "OUT OF SERVICE" COLUMN ON THE OTHER SIDE OF THIS CERTIFICATE HAVE BEEN SATISFACTORILY COMPLETED

SIGNATURE OF REPAIRMAN NAME OF SHOP (GARAGE)

REPAIR WORK COMPLETED
TIME

MOTOR CARRIER CERTIFICATION OF ACTION TAKEN

I CERTIFY THAT ALL VIOLATIONS NOTED UPON THIS REPORT HAVE BEEN CORRECTED AND ACTION HAS BEEN TAKEN TO ASSURE COMPLIANCE WITH THE MOTOR CARRIER SAFETY REGULATIONS INSOFAR AS THEY ARE APPLICABLE TO MOTOR CARRIERS AND DRIVERS

SIGNATURE OF CARRIER OFFICAL

HSE Manage

7-8-09

ATTENTION DRIVER

This report must be furnished to the motor carrier whose name appears on this report

ATTENTION DRIVER

TRC Chapter 644, Revised Statutes, requires the Motor Carrier to execute the above certification

and return this report to

MOTOR CARRIER BUREAU TEXAS DEPARTMENT OF PUBLIC SAFETY PO BOX 4087

AUSTIN TX 78773-0521

IMPORTANT MESSAGES

Any enforcement actions taken against you and any subsequent court actions are intended to secure compliance with the traffic laws and all other users of the highways. Failure to comply with your written promise to appear in court as made on this citation will constitute a separate offense with which you may be charged and result in warrants being issued for your arrest. Failure to appear in court or failure to satisfy a judgement ordering payment of a fine and cost in the manner ordered by the court may result in the denial of renewal of your driver's license.

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To obtain IFTA information contact the State of Texas Comptrollers Office at 1-800-252-1383 or visit their website at www.window.state.tx.us/taxinfo/fuels/ifta.html

| TX094Q9DCE07 | HOUSTO | N POLICE DEP | ARTMENT | 654 6 | \4 F4 \0 · | LEVEL |
|--|---|--|--|------------------|--|-------------------------------------|
| ARREST TKT 9 - 15 PASS. I | POD UTDP | | | CP#:(| TPTR. | TB 1 |
| COM. VEH. 16 PASS. FOR I | | • | CONSTRUCTION 20N | E MEIXED | ROADSIDE | |
| | | | | SCALE | | ALCH DS |
| ☑ CDL ☐ SCHEDULE ☐ | CHARTER |] INTRASTATE | OCCUPIED OCCUPIED | HOUSE _ | | 🗌 SW 🞦 TE |
| | 5:45PM COUNTY: HARRI | | | | | MP#: 29 869392 |
| Add/City/St/Zip: | | | | | ICC/MC#: | 400234 |
| OWNER: CES ENVIRONMENTAL | | | | | TXDOT#: | 005516524C |
| ADD/CITY/ST/ZIP:4904 GRIGGS ROAD H | | | | | _ | |
| | 00310N, TR //021 | P. C. C. | EV DA | (b) (C) | PHONE#: | 7136761460 |
| operator. | | RACE/S | | _(b) (b) | _ MED CARD: | |
| Add/City/St/Zip: (b) (6) | | | DL #: <u>((</u> | 0) (6) | ST: TX | DL CLASS: A |
| VEH SEARCH: YES NO R | EASON FOR STOP: WARN | CITATION | ☐ INSPECTION | CONTRABAND | LOCATED: | □YES ☑NO |
| TYPE OF SEARCH: CONSENT PC | VAN-12-0-2-1-0-2-1-0-1-0-1-0-1-0-1-0-1-0-1- | an were reward to the control of the | F CONTRABAND: | | PONS CURRI | ENCY OTHER |
| | Init TYPE MAKES CO# | | and the second s | 100 | | |
| _ | 1 TR MACK 108 | (b) (b) T | <u> </u> | . ~ | | |
| ly | | | | | | |
| <u> </u> | | | | | | |
| SIGNATURE: | | | 1200:0 | o befor | - 27 - NI | a |
| I HEREBY PROMISE TO APPEAR AT THE PLACE DESIGNATED IN THIS NOTICE. | | | 72000 | he alor | 1-20-0 | 1 |
| NOT A PLEA OF GUILTY) | A 00 | | Dul | 1)6-102 | | |
| COPY RECEIVED BY | GROSS WEIGHT | : | GRO | UP WEIGHT: | | |
| YOU ARE HEREBY NOTIFIED TO APPEAR | | | LOAD | DISP: | | |
| JUDGE: Houston Municipal Court #1 | OURT: Municipal | PCT./PLAC | E: 0/1 PERM | rr #: | | |
| PHONE: (713) 837-0311 ON/BE | FORE Wed, 22-July-2009 | AT 09:00 | | r #1 50000 | GVWR # | :1 10 |
| ADDRESS: 1400 LUBBOCK HOUSTON TX 770 | 102 | | RG W | | GVWR # | |
| | | VSA DECAL-TT | CVSA DECAL-ST | | | |
| | | | 0,0,1,0,0,0,0,0,0 | | | |
| | <u> </u> | <u>-</u> | | | | |
| SHIPPING #: | CONSIGNOR: | | | CONSIGNEE: | | |
| COMMODITY: EMPTY | ORIGIN: | | TX | DESTINATION: | 1 | TX |
| HM CATEGORY CODE | E RQ? HW? PLACARDS REQ? | 1 7/8 2 1/8 | 1 5/8 | | ALLEGED SP | EED |
| NA | | - R | | | SPEED LIMI | |
| 1 | SPEC. TANK | AX 1 AX 2 1 1 3/4 1 1/4 | AX 3 AX 4 AX 5 | AX 6 AX 7 AX | RADAR CAL. | |
| | | 1 3/4 1 1/4 | 1 7 6 | | | |
| | POST | <u> </u> | VIOLATIONS DISC | | | |
| No. Y/N DISP | BRAKE OUT OF ADJUST | | DIRECTIONS ON BA | | | |
| Yes 393.47(E) 1 | OIL/GREASE LEAK - DRI | | | 120 AT 2 1/ | <u> </u> | |
| 393.11 1 | DEFECTIVE BACKUP LAMP | | | | | |
| | | | 100 (00100) 10 00 | | | |
| 393.53(B) 1 | DEFECTIVE/INOPERATIVE | | | | | |
| 393.53(B) 1 | DEFECTIVE/INOPERATIVE | E AUTOMATIC SI | ACK (BRAKE) ADJU | STERS - RX2T30 | AT 2 1/8 | |
| | | | | | | |
| | · · · · · · · · · · · · · · · · · · · | · · · · · · · · · · · · · · · · · · · | *********** | · | | |
| | VEHICLE/DRIVE | | VICE NOTICE | | | |
| VEHICLE Pursuant to authority containe of Service" the vehicle/s with defects | d in TRC Chapter 644 I hereby | declare "Out | DRIVER Pursuant t TRC Chapter 644 I | o authority cont | ained in OOS | DISPOSITIONS Repaired at Scene / |
| column of this report. No person shal applied to these vehicles or operate s | .1 remove the out of service st | tickers | declare the drive | r named on this | report Obta | nined Oper. Auth. |
| defects have been repaired and the veh condition, or proper operating authori | icles have been restored to sa | | permit or require | driver to drive | or Repa | air Service Other |
| SEE CONTINUATION SHEET X TROOPER | | | -posses only motor | | ט. ט | Jnknown Driver OOS |
| D AND A= YES, WEATHER CLEAR AND DRY, | | | | | | |
| VEH FLAGGED DOWN FROM 610 SB INTO 30 | V E INUF N | | Χ | | <u></u> _ | |
| | | | COPY RECEIVE | D BY | —————————————————————————————————————— | Log Book Exemption |
| INSPECTED BY: | ID/REGION/DISTRICT/AREA I | TIME COMPLETED | | | ROMMEL | |
| GARCIA, ROMMEL | 2V-113956 2 9 V | 6:51PM | REFERRAL ID | | | |
| CHARGES FILED BY: GARCIA ROMMET | 2V-113956 2 9 V | | BRAKES INSPECTE | D BY: 2V-1130 | 56 2 9 V | |

Houston Municipal Courts

Municipal Courts Administration Department 1400 Lubbock, Houston, TX 77002-0311 713-837-0311

Forwarding Service Requested



Arraignment Notice

AR1

07/01/2009

Make/Model TRAILER MACK License # (b) (6)

State TX

DOB: 11/25/1959

<u>JOSE F SANCHEZ</u>

DEAR JOSE F SANCHEZ,

THIS NOTICE SERVES TO REMIND YOU THAT YOU ARE SCHEDULED FOR AN ARRAIGNMENT AS FOLLOWS:

Location: 10 (LUBBOCK)

1400 LUBBOCK HOUSTON, TX 77002

Date: 07/22/2009 Time: 9:00 PM

YOU MUST APPEAR IN COURT AS SCHEDULED ABOVE OR RESOLVE YOUR CASE BY SELECTING ONE OF THE OPTIONS LISTED BELOW BEFORE YOUR SCHEDULED COURT DATE. FAILURE TO RESOLVE YOUR CITATION(S) IN THE MANNER LISTED MAY RESULT IN (1) ISSUANCE OF A WARRANT FOR YOUR ARREST AND AN ADDITIONAL CHARGE FOR FAILURE TO APPEAR (WITH A FINE OF \$200); (2) DENIAL OF THE RENEWAL OF YOUR DRIVERS LICENSE, (3) DENIAL OF THE RE-REGISTRATION OF ANY MOTOR VEHICLE.

IF YOU DECIDE TO PAY YOUR FINES, THE PAYMENT MUST BE POSTMARKED OR RECEIVED PRIOR TO YOUR COURT DATE

| Ticket Number | Offense Date | Offense Description | Case Number | Fine, Costs and Fees |
|------------------|-----------------|---|-----------------|-------------------------|
| TCE94Q070 | 06/19/2009 | BRAKES OUT OF ADJUSTMENT ON (MOTOR VEHICLE) (TRAI | 2009 TR 0519723 | 200.00 |

Total Due 200.00

OPTIONS:

- 1. Appear in person at any of the Court locations (see times and locations on reverse) and:
 - A. Pay the fine(s)
 - Apply for Deferred Disposition
 - C. Request a trial by Judge or Jury
- 2. Pay the fine(s) by one of the following methods:
 - A. Mail (must be postmarked by the scheduled court date- DO NOT send cash)
 - B. Credit Card
 - Western Union Quick Collect C.
 - D. Online

MAILING ADDRESS

CITY OF HOUSTON

Municipal Courts 1400 Lubbock

Houston, TX 77002-1553

WEBSITE

HTTP://WWW.HOUSTONTX.GOV/COURTS/

"Forms and Instructions are on reverse"

PHONE NUMBER

311 or 713-837-0311

TDD Hearing Impaired

713-247-8591

Pay in Person

You may make payments in person at any facility of the Houston Municipal Courts. Please bring this notice with you when you pay in person. The Court accepts Cash, Money Orders, Personal and Cashier Checks, and Credit Cards listed below:

Payment Locations - 1400 Lubbock 7AM - 10PM, Mon - Sat 3203 Dairy Ashford 8AM - 5PM, Mon - Fri

| | | |

8300 Mykawa 8AM - 5PM, Mon - Fri 3915 Rustic Woods Drive 8AM - 4PM, Wed

2855 Bay Area BLVD 8AM - 4PM, Thu 9455 West Montgomery Rd. 8AM - 4PM, Fri

Pay By Mail

Do not send Cash. Payment will be accepted in the form of Cashier's Check, Personal Check and Money Order.

PAYMENT SHOULD BE ADDRESSED TO:

THE FOLLOWING PLEA WAIVER MUST BE SIGNED:

CITY OF HOUSTON

I hereby waive my right to a Trial by Jury and enter a plea of "No Contest,"

MUNICIPAL COURTS - MAIL DIVISION

1400 LUBBOCK

HOUSTON, TX 77002

Signature

Date

Pay by Credit Card

You may use this form or the form on the back of your ticket in order to pay by Credit Card. This notice must be included with your payment. The total amount charged will be the amount shown on the front of the notice. Please note that disputed charges or stop payments may result in issuance of a Warrant for your arrest.

(CIRCLE ONE)

Master Card

American Express

>>FILL OUT EVERY BLANK<<

Discover

Visa

Credit Card No. Expiration Date

Name on Card Your Name

Signature Social Security No

Street Address City/State/Zip

Home Phone Work Phone

I hereby waive my right to a Trial by Jury And enter my plea of "No Contest"

Signature

Date

Pay by Western Union Quick Collect

"The fastest way to send money"

You may pay by Quick Collect at any Western Union location. To find the nearest location, call 1-800-325-6000 or look in the telephone directory. Your payment will usually be received and applied within the hour.

Use the information below to fill out the Quick Collect form. All of the information must be complete and correct in order for the Court to receive and process the payment.

Pay to: Houston Municipal Courts

Code - City: TICKET

State: TEXAS

Your Full Name:

Sender's Account Number with Company.

Your Telephone Number:

Write your Driver's License number and the Cause Numbers

Of all Tickets for which you are paying. The Cause Number is located in

the upper right corner of the Ticket.

IF THE COURT CANNOT PROCESS YOUR PAYMENT, IT WILL BE RETURNED TO WESTERN UNION.

Pay Online

You may pay online at HTTP://WWW.HOUSTONTX.GOV/COURTS/

| TX094Q9DCE07 | HOUSTON POLICE DEPARTMENT | CP#: 0151818 1 |
|--|--|---|
| ☑ ARREST TKT ☐ 9 - 15 PASS. FOR HIRE ☑ COM, VEH. ☐ 16 PASS. FOR HIRE | CONSTRUCTION ZO SP PROG: ☑ INTERSTATE □ VES ☑ NO | NE □FIXED ☑ROADSIDE □ ALCH □ DS |
| ☑ CDL ☐ SCHEDULE ☐ CHARTER | SP PROG: ☑ INTRASTATE ☐ YES ☑ NO ☐ INTRASTATE ☐ OCCUPIED | SCALE SW TE |
| DATE: 06/19/2009 TIME: 5:45PM | COUNTY: HARRIS HWY: (1) IH-061 | 0 IN HARRIS CO. (0-37) MP#: 29 |
| Lessee/MC: Add/City/St/Zip: | | USDOT#: 869392 ICC/MC#: 400234 |
| OWNER: CES ENVIRONMENTAL SERVICES I | NC . | TXDOT#: 005516524C |
| ADD/CITY/ST/ZIP:4904 GRIGGS ROAD HOUSTON, TX | 77021 | PHONE#: 7136761460 |
| Operator: JOSE F SANCHEZ | RACE/SEX: HM DOB: | (b) (6) MED CARD: |
| Add/City/St/2ip: (b) (6) | DL #: | b) (6) ST: TX DL CLASS: A |
| VEH SEARCH: ☐ YES ☑ NO REASON FOR TYPE OF SEARCH: ☐ CONSENT ☐ PC ☐ INC. TO | | CONTRABAND LOCATED: ☐YES ☑NO ☐DRUGS ☐WEAPONS ☐CURRENCY ☐OTHER |
| UNITYPE OF SEARCH. CONSERVI — CON | AKE GOV Nepate State VIN | |
| SIGNATURE: | | |
| I HEREBY PROMISE TO APPEAR AT THE TIME AND PLACE DESIGNATED IN THIS NOTICE. (THIS IS NOT A PLEA OF GUILTY) | ж оо | |
| COPY RECEIVED BY | GROSS WEIGHT: GRO | OUP WEIGHT: |
| YOU ARE HEREBY NOTIFIED TO APPEAR | j | DISP: |
| · | A 7-1- 0000 AD 00-00 00 00 | IT #: |
| PHONE: (713) 837-0311 ON/BEFORE Wed, 2 ADDRESS: 1400 LUBBOCK HOUSTON TX 77002 | 100 (1 | T #1 50000 GVWR #1 0 |
| SEAL #'S REMOVED: DEPT. SEAL #; INSTA | RG W ALLED CVSA DECAL-TT CVSA DECAL-ST | T #2 GVWR #2 CVSA DECAL-ST |
| | | |
| SHIPPING #: | CONSIGNOR: | CONSIGNEE: |
| COMMODITY: EMPTY | ORIGIN: TX | DESTINATION: TX |
| HM CATEGORY CODE RQ? HW | | ALLEGED SPEED |
| NA | AX 1 AX 2 AX 3 AX 4 AX 5 | SPEED LIMIT |
| | SPEC. TANK 1 1/4 1 7/8 A 3 A 4 A 5 | AX 6 AX / AX 8 RADAR CAL. |
| TICKET VIOL. CITE # Unlt OOS : OOS !POST! | VIOLATIONS DISC | OVERED |
| No. Y/N DISP ACC | DRIVER: PLEASE COMPLY WITH DIRECTIONS ON BA | CK SIDE OF THIS FORM |
| res 1 | OUT OF ADJUSTMENT - CLAMP / ROTO - RX2 REASE LEAK - DRIVE SHAFT TO X2 DRIPPING OIL | 2 T20 AT 2 1/8 |
| | TIVE BACKUP LAMP - NONE | |
| 393.53(B) 1 DEFECT | TIVE/INOPERATIVE AUTOMATIC SLACK (BRAKE) ADJU | STERS - RX1 T20 AT 1 7/8 |
| 393.53(B) 1 DEFECT | PIVE/INOPERATIVE AUTOMATIC SLACK (BRAKE) ADJU | STERS - RX2T30 AT 2 1/6 |
| | | |
| | | |
| | VEHICLE/DRIVER OUT OF SERVICE NOTICE | |
| of Service" the vehicle/s with defects followed by column of this report. No person shall remove the applied to these vehicles or operate such vehicles defects have been repaired and the vehicles have be condition, or proper operating authority has been SEE CONTINUATION SHEET X TROOPER COMMENTS: | out of service stickers declare the drive until the out of service Out of Service. Neen restored to safe operating permit or require | notify and A. Repaired at Scene / Detained Oper. Auth. No motor carrier shall B. Towed/Escorted to Repair Service |
| D AND A= YES, WEATHER CLEAR AND DRY, TRAFFIC M VEH FLAGGED DOWN FROM 610 SB INTO 300 E LOOP N | | ↓ Log Book Exemption |
| | COPY RECEIVE DISTRICT/AREA TIME COMPLETED REPORT PREPARED REFERRAL ID REFERRAL ID | on merculatur promote mentra a antica a antica a francisco a construir de la constanta a constanta a constanta |
| CHARGES FILED BY: CARCTA POMMET 2V-113056 | BRAKES INSPECTE | D BY: (2V-112056 2 0 V |





HOUSTON POLICE DEPARTMENT

| INSPECTION # | CF# | | DATE | | | |
|----------------|-----|---------|------|-----------|-----------|--|
| TX094Q9DCE07-0 | | 0151818 | | 6/19/2009 | 5:45:00PM | |
| MOTOR CARRIER | | | | | | |

CES ENVIRONMENTAL SERVICES INC

OPERATOR

SANCHEZ

<u>Jose</u>

<u>F</u>

CONTINUATION SHEET

FIRST NAME ΜI LAST NAME NOTE TO DRIVER: This report must be furnished to the motor carrier whose name appears on this report. NOTE TO MOTOR CARRIER: TRC Chapter

| | | | | | certification on the reverse side and return this report to Texas Department of Public Safety, Motor Carrier 78773-0001 within fifteen (15) days. | |
|--------|---------|------|-------------|-------------|--|---|
| | - | | | | VIOLATIONS | |
| TICKET | AIOF GL | CE # | Unit No. | OOS DISP | | _ |
| | 393.47(| E) | 1 | | BRAKE OUT OF ADJUSTMENT - CLAMP / ROTO - RX1 T20 AT 1 7/8 | |

| - | VEHICLE/DRIV | ER OUT OF SER | VICE NOTICE | | |
|--|--|--|---|--|--|
| WEHICLE Pursuant to authority contain of Service" the vehicle/s with defect column of this report. No person sha applied to these vehicles or operate defects have been repaired and the ve condition, or proper operating author SEE CONTINUATION SHEET X TROOPER | s followed by "YES" in the Ou ll remove the out of service such vehicles until the out o hicles have been restored to ity has been obtained. | t of Service stickers of service | DRIVER Pursuant to auth- TRC Chapter 644 I hereb declare the driver name Out of Service. No moto permit or require drive operate any motor vehic | y notify and d on this report r carrier shall r to drive or | OOS DISPOSITIONS A. Repaired at Scene / Obtained Oper. Auth. B. Towed/Escorted to Repair Service D. Other U. Unknown N. Driver OOS |
| D AND A= YES, WEATHER CLEAR AND DRY VEH FLAGGED DOWN FROM 610 SB INTO 3 | | } | COPY RECEIVED BY | | Log Book Exemption |
| INSPECTED BY: GARCIA, ROMMEL | ID/REGION/DISTRICT/AREA 2V-113956 2 9 V | rime Completed 6:51PM | REPORT PREPARED BY: | GARCIA, ROMMEL | |
| CHARGES FILED BY: GARCIA, ROMMEL | 2V-113956 2 9 V | | BRAKES INSPECTED BY: | 2V-113956 2 9 V | |





| ID ÎN MERA DIN NIN WE DU IN SELECTION DI PROGRAFI M |
|---|
| HOUSTON POLICE |
| DEPARTMENT |

CONTINUATION SHEET

| INSPECTION # | CP # | DATE | |
|----------------|---------|-------------------|-----|
| TX094Q9DCE07-0 | 0151818 | 6/19/2009 5:45:00 |)PM |
| MOTOR CARRIER | | | |
| | | | |

OPERATOR

SANCHEZ LAST NAME

JOSE FIRST NAME

<u>F</u> ΜI

NOTE TO DRIVER: This report must be furnished to the motor carrier whose name appears on this report. NOTE TO MOTOR CARRIER: TRC Chapter 644 requires the Motor Carrier to execute the certification on the reverse side and return this report to Texas Department of Public Safety, Motor Carrier

| Safety | y Sectio | on, PO | Box 408 | 7, Au | stin, T | exas | 78773-0001 within fifteen (15) days. | |
|--------|----------|--------|---------------|------------|-------------|------|---|--|
| | | | | | | | VIOLATIONS | |
| TICKET | VIOL. | CITE | # Unit No. | OOS Y/N | OOS DISP | POST | | |
| | 393 | .47(E) | 1 | | | | BRAKE OUT OF ADJUSTMENT - CLAMP / ROTO - RX1 T20 AT 1 7/8 | |
| | | | | | | | | |

| | VEHICLE/DRIV | ER OUT OF SEF | RVICE NOTICE | | |
|---|--|--|--|--|--|
| VEHICLE Fursuant to authority contain of Service" the vehicle/s with defect column of this report. No person sha applied to these vehicles or operate defects have been repaired and the ve. condition, or proper operating author SEE CONTINUATION SHEET X TROOPER | s followed by "YES" in the Ou ll remove the out of service such vehicles until the out o hicles have been restored to ity has been obtained. | t of Service stickers of service | DRIVER Pursuant to auth TRC Chapter 644 I hereb declare the driver name out of Service. No moto permit or require drive operate any motor vehic | y notify and d on this report r carrier shall r to drive or | OOS DISPOSITIONS A. Repaired at Scene / Obtained Oper. Auth. B. Towed/Escorted to Repair Service D. Other U. Unknown N. Driver OOS |
| D AND A= YES, WEATHER CLEAR AND DRY VEH FLAGGED DOWN FROM 610 SB INTO 3 | | | X Sould COPY RECEIVED BY | | ☑ Log Book Exemption |
| INSPECTED BY: GARCIA, ROMMEL | ID/REGION/DISTRICT/AREA 2V-113956 2 9 V | FIME COMPLETE | REPORT PREPARED BY: | GARCIA, ROMMEL | |
| CHARGES FILED BY: GARCIA, ROMMEL | 2V-113956 2 9 V | <u> </u> | BRAKES INSPECTED BY: | 2V-113956 2 9 V | |

ANY ENTRIES IN THE VIOLATIONS' SECTION OF DRIVER'S COPY, WHERE THERE IS "YES" IN THE TICKET BOX, INDICATES CHARGES FILED AGAINST THE DRIVER THIS WILL REQUIRE CONTACTING THE JUDGE FOR APPROPRIATE DISPOSITION

JUDGE INFORMATION IS IN HEAVY BORDERED BOX ON DRIVER'S COPY

PAYMENTS FOR FINES SHOULD BE SENT TO THE COURT LISTED ON THE DRIVERS COPY. DO NOT SEND PAYMENTS TO TX DPS/MCB.

| I CERTIFY THAT THE REQUIRED RE OF THIS CERTIFICATE HAVE BEEN : | CERTIFICATION OF REPAIRMA PAIRS SHOWN IN THE "OUT OF SERV SATISFACTORILY COMPLETED | | HE OTHER SIDE |
|---|--|--------------------------------------|---------------|
| SIGNATURE OF REPAIRMAN | NAME OF SHOP (GARAGE) | REPAIR WORK | COMPLETED |
| Oldifference of Thair Farming of | (4, 33, 34, 34, 34, 34, 34, 34, 34, 34, 3 | DATE | TIME |
| I CERTIFY THAT ALL VIOLATIONS NO | | EN CORRECTED AND FETY REGULATIONS | |
| SIGNATURE OF CARRIER OFFICAL | TITLE | DATE | |

ATTENTION DRIVER

This report must be furnished to the motor carrier whose name appears on this report

ATTENTION DRIVER

TRC Chapter 644, Revised Statutes, requires the Motor Carrier to execute the above certification

and return this report to

MOTOR CARRIER BUREAU TEXAS DEPARTMENT OF PUBLIC SAFETY PO BOX 4087 AUSTIN TX 78773-0521

IMPORTANT MESSAGES

Any enforcement actions taken against you and any subsequent court actions are intended to secure compliance with the traffic laws and all other users of the highways. Failure to comply with your written promise to appear in court as made on this citation will constitute a separate offense with which you may be charged and result in warrants being issued for your arrest. Failure to appear in court or failure to satisfy a judgement ordering payment of a fine and cost in the manner ordered by the court may result in the denial of renewal of your driver's license.

A second or subsequent conviction of failure to maintain financial responsibility will result in the suspension of your driver's license and motor vehicle registration unless you file and maintain proof of financial responsibility with the Department of Public Safety for two (2) years from the date of conviction. The Department may waive the requirement to file proof of financial responsibility if you file satisfactory evidence with the Department showing that at the time this citation was issued the vehicle was covered by a liability insurance policy or that you were otherwise exempt from the requirements to provide evidence of financial responsibility.

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"A conviction of an offense under a traffic law of this state or a political subdivision of this state may result in the assessment on your driver's license of a surcharge under the Driver Responsibility Program."

A request for an out-of-service review, regarding operating authority, must be made in writing and forwarded to the manager of the Motor Carner Bureau if requested, a review will be scheduled and conducted by the manager of the Motor Carner Bureau or the director's designee within 10 days of the issuance of the out-of-service order. A request for review should be addressed to the Texas Department of Public Safety, Motor Carner Bureau, P.O. Box 4087, Austin, TX 78773-0521 or may be sent by facsimile transmission to (512)424-5712 or via electronic mail at MotorCarnerBureau@bxdps.state.tx.us. The Department may conduct the review by telephone conference call.

To obtain a TXDOT Motor Carrier Insurance Certificate or Single State Registration - contact the Texas Department of Transportation at 1-800-299-1700 or visit their website at www.dot.state.tx.us

To obtain a USDOT Number contact the Federal Motor Carner Safety Administration at 1-800-832-5660 or visit their website at www.fmcsa.doi.gov/lactsfigs/formspubs.htm

To obtain IFTA information contact the State of Texas Comptrollers Office at 1-800-252-1383 or visit their website at www.window.state.tx.us/taxinfo/fuels/lifta.html



HOUSTON POLICE DEPARTMENT TRUCK ENFORCEMENT UNIT CITATION

| TICKET# | C | COURT | | COURT DA | ATE A | ND TIME | |
|------------------------------------|-------|---|---------|-----------|--------|--------------|-----|
| TCE94Q070 | | louston Municipal Court #10 in Harris C | О. | 7/22/2009 | 9:0 | 0:00PM | |
| DPS REPORT# | | COURT ADDRESS | | | | COURT PHON | IE# |
| TX094Q9DCE07 | _ 1 | 400 LUBBOCK HOUSTON, TX 77002 | | | | (713) 837-03 | 311 |
| DRIVER LICENSE# | STATE | DRIVER NAME | | RACE/SEX | DOB | | AGE |
| (b) (6) | TX | SANCHEZ, JOSE F | | HM | (b) (6 | 6) | 49 |
| HOME ADDRESS | | | НОМЕ РН | ONE# | `` | WORK PHON | E# |
| (b) (6) | | | (b) (6) | | | (000) 000-00 | 000 |
| (b) (6) HOME ADDRESS (b) (6) | TX | SANCHEZ, JOSE F | | | (b) (6 | WORK PHON | E# |

UNIT DETAILS TYPE MAKE STATE TR MACK TX

VIOLATIONS

| OFFENSE | DATE | MPH SPEED | MPH SPEED | OFFENSE | LOCATION | BEAT |
|---------|-------------------------|----------------|-----------|---------|------------------|------|
| JUNE 19 | 9, 2009 5:45:00PM | 0 | 0 | 300 EAS | T LP N SER W | 9C10 |
| CODE | VIOLATION | | | | TO-WIT | |
| - | BRAKE OUT OF ADJUSTMENT | - CLAMP / ROTO | | | RX2 T20 AT 2 1/8 | |

| VEHICLE SEARCHED | SEARCH TYPE | OFFICER |
|------------------|-------------|------------------|
| NO | | GARCIA, R 113956 |

Your failure to appear, failure to pay, or failure to satisfy a judgement ordering payment of a fine and costs, may result in:

- 1) A warrant issued for your arrest
- 2) A charge of Failure to Appear and \$205 fine
- 3) Denial of Driver's License renewal
- 4) Denial of Motor Vehicle registration or renewal and
- 5) A \$30 DPS fee for each violation charged

| DRIVER SIGNATURE: | DATE: | |
|-------------------|-------|--|
| | | |

This is not an admission of guilt, but I do acknowledge receipt of this notice and I will appear in court at the time and place designated above. I am the person named and identified in this ticket.

| | STON POLICE DEPARTMENT |
|--|--|
| TAOS IQSECTOR | CP#: 0151818 1 |
| ✓ ARREST TKT 1 9 - 15 PASS. FOR HIRE | CONSTRUCTION ZONE ☐FIXED ☑ROADSIDE |
| ACCIDENT 16 PASS. NOT FOR HIRE SP PROG: | |
| ☑ CDL ☐ SCHEDULE ☐ CHARTER | ☐ INTRASTATE ☐ OCCUPIED HOUSE ☐ SW ☐ TE |
| DATE: 06/19/2009 TIME: 5:45PM COUNTY: H | ARRIS HWY: (1) IH-0610 IN HARRIS CO. (0-37) MP#: 29 |
| Lessee/MC: | USDOT#: 869392 |
| Add/City/St/Zip: | ICC/MC#: 400234 |
| OWNER: CES ENVIRONMENTAL SERVICES INC | TXDOT#: 005516524C |
| | |
| ADD/CITY/ST/ZIP:4904 GRIGGS ROAD HOUSTON, TX 77021 | PHONE#: 7136761460 |
| Operator: JOSE F SANCHEZ | RACE/SEX: HM DOB: (0) MED CARD: |
| Add/City/St/Zip: (b) (6) | DL #: (D) (ST: TX DL CLASS: A |
| VEH SEARCH: ☐ YES ☑ NO REASON FOR STOP: ☐ WAI | RN CITATION DINSPECTION CONTRABAND LOCATED: YES MO |
| TYPE OF SEARCH CONSENT PC INC. TO ARREST IN | IVENTORY TYPE OF CONTRABAND: □DRUGS □ WEAPONS □CURRENCY □OTHER |
| UNITYPE MAKE CO | Plate Stat: VIN |
| 1 TR MACK 108 | 3 (b) (6) TX |
| V ash | \$61 AB 101 191 AB 101 AB 1 |
| X Axxivag | |
| SIGNATURE: | |
| I HEREBY PROMISE TO APPEAR AT THE TIME AND | |
| PLACE DESIGNATED IN THIS NOTICE. (THIS IS NOT A PLEAFOF GUILTY) | |
| EZ COPY RECEIVED BY GROSS WEIG | GROUP WEIGHT: |
| V 0011 12021 120 | |
| YOU ARE HEREBY NOTIFIED TO APPEAR | LOAD DISP: |
| JUDGE: Houston Municipal Court #10 COURT: Municipal | PCT./PLACE: 0/1 PERMIT #: |
| PHONE: (713) 837-0311 ON/BEFORE Wed, 22-July-2009 | AT 09:00:00PM RG WT #1 50000 GVWR #1 0 |
| ADDRESS: 1400 LUBBOCK HOUSTON TX 77002 | RG WT #2 GVWR #2 |
| SEAL #'S REMOVED: DEPT. SEAL #; INSTALLED | CVSA DECAL-TT CVSA DECAL-ST CVSA DECAL-ST |
| | |
| CULT DITUG (I. | Tanas and |
| SHIPPING #: CONSIGNOR: | CONSIGNEE: |
| COMMODITY: EMPTY ORIGIN: | TX DESTINATION: TX |
| HM CATEGORY CODE RQ? HW? PLACARDS R | EQ? 1 7/8 2 1/8 1 5/8 ALLEGED SPEED |
| NA 🗆 | SPEED LIMIT |
| SPEC. TAN | TK AX 1 AX 2 AX 3 AX 4 AX 5 AX 6 AX 7 AX 8 RADAR CAL. |
| S. Carlotte and Ca | |
| | I 1 3/4 1 1/4 1 7/8 |
| TICKET VIOL CITE # Unit! OOS OOS POST | VIOLATIONS DISCOVERED |
| No. Y/N DISP ACC DRIVER:PLE | VIOLATIONS DISCOVERED ASE COMPLY WITH DIRECTIONS ON BACK SIDE OF THIS FORM |
| Yes 393.47(E) 1 DISP ACC DRIVER:PLE BRAKE OUT OF ADD | VIOLATIONS DISCOVERED ASE COMPLY WITH DIRECTIONS ON BACK SIDE OF THIS FORM FUSTMENT - CLAMP / ROTO - RX2 T20 AT 2 1/8 |
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JUDGE INFORMATION IS IN HEAVY BORDERED BOX ON DRIVER'S COPY

PAYMENTS FOR FINES SHOULD BE SENT TO THE COURT LISTED ON THE DRIVERS COPY. DO NOT SEND PAYMENTS TO TX DPS/MCB.

CERTIFICATION OF REPAIRMAN

I CERTIFY THAT THE REQUIRED REPAIRS SHOWN IN THE "OUT OF SERVICE" COLUMN ON THE OTHER SIDE OF THIS CERTIFICATE HAVE BEEN SATISFACTORILY COMPLETED

SIGNATURE OF REPAIRMAN

NAME OF SHOP (GARAGE)

REPAIR WORK COMPLETED

6-29-09

Œ

MOTOR CARRIER CERTIFICATION OF ACTION TAKEN

Manag

I CERTIFY THAT ALL VIOLATIONS NOTED UPON THIS REPORT HAVE BEEN CORRECTED AND ACTION HAS BEEN TAKEN TO ASSURE COMPLIANCE WITH THE MOTOR CARRIER SAFETY REGULATIONS INSOFAR AS THEY ARE APPLICABLE TO MOTOR CARRIERS AND DRIVERS

SIGNATURE OF CARRIER OFFICAL

TITLE

DATE

ATTENTION DRIVER

ATTENTION DRIVER

This report must be furnished to the motor carrier whose name appears on this report

TRC Chapter 644. Revised Statutes, requires the Motor Camer to execute the above certification

and return this report to

MOTOR CARRIER BUREAU TEXAS DEPARTMENT OF PUBLIC SAFETY PO BOX 4087 AUSTIN TX 78773-0521

IMPORTANT MESSAGES

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You may be able to require that this charge be dismissed by successfully completing a driving safety course or a motorcycle operator training course. You will lose that right if, on or before your appearance date, you do not provide the court with notice of your request to take the course. This article does not apply to an offense committed by a person who holds a commercial driver's license

"A conviction of an offense under a traffic law of this state or a political subdivision of this state may result in the assessment on your driver's license of a surcharge under the Driver Responsibility Program."

A request for an out-of-service review, regarding operating authority, the be made in virting and forwarded to the manager of the Motor Carrier Bureau if requested, a review will be scheduled and conductive the manager of the Motor Carrier Bureau or the directorized designee within 10 days of the issuance of the out-of-service order and to review should be addressed to the Texas Department of Public Safety, Motor Carrier Bureau, P.O. Box 4087, Austin, TX 26773-0522 of may be sent by facsimile transmission to (512)424-5712 or via electronic mail at MotorCamerBureau@txdps state to us. The Department may conduct the review by telephone conference call

To obtain a TXDOT Motor Carrier Insurance Certificate or Single State Registration - contact the Texas Department of Transportation 1-800-299-1700 or visit their website at www dot state tx us

To obtain a USDOT Number contact the Federal Motor Carner Safety Administration at 1-800-832-5660 or visit their website a www.fmcsa.dot.gov/factsfigs/formspubs.htm

To obtain IFTA information contact the State of Texas Comptrollers Office at 1-800-252-1383 or visit their website at www window state tx us/taxinfo/fuels/ifta html



Equipment and Facility Work Order

| Unit: | 108 | | Date: 06-23-09 | Miles: | 16 | 191 | | | |
|----------------|-------------------|------------|--|------------------------|--------------------|--------------------------|-----------------|-------------|------------|
| | npany Owned ν | Yes | No Bill To: | • | | | | | |
| | - | | | | | | | <u></u> | |
| Job# | 1.7 6 | | 10.01 | Description Of Repairs | | TW | | SGA | <u> </u> |
| 1 | BRAKE | 3 OUT OF | ADJUBIMENT | | | TW | | DSP | |
| 2 | BACK | • – | ns | | | FS | | REC | |
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| متر و المراجعة | | | | | | | | T 5 | Total Cost |
| Job# | Work Code | Maint Item | MOUDICA ALMO | rk Performed | Tech All 8 | Hours | Labor\$ | Parts \$ | Total Cost |
| 1 | RIL | 11/11 | AUSINI DIANGS, | 30 BACK-UD CLARY WARK | 1 741000 1 14 1 | 11.5 | | | |
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| Job# | | Part Des | cription/Sublet | Part Number/Sublet | <u> </u> | | Qty | Cost | Ext Cost |
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| | Reviewed By: | | | _ D: | ata Input By: | | | | |

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| DATE: 07 | /24/2009 TIME: | - | COUNTY: HAR | _ | HWY: (5) 610 | | | | MP#: |
| Lessee/MC | | | | | | <u> </u> | | | 392 |
| Add/City/St/Zip |): | | | | | | | ICC/MC#: 400 | 234 |
| OWNE | R: CES ENVIRONMENTA | L SERVICES IN | rc | | | | | TXDOT#: 005 | 516524C |
| ADD/CITY/ST/21 | P:4904 GRIGGS ROAD | HOUSTON, TX | 77021 | · · · · · · · · · · · · · · · · · · · | | | | PHCNE#: 713 | 86761460 |
| Operator: | PETER SEMIEN | | | RACE/S | EX: BM DO | (b) (6) |) | MED CARD: 10- | 3-2010 |
| Add/City/St/Zip | (b) (6) | | | | DL #: | (b) (6) | | ST: TX DL | CLASS: A |
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| YOU ARE HEREBY | NOTIFIED TO APPEAR | <u> </u> | | | ro | AD DISP: | 7 | ———————————————————————————————————— | |
| JUDGE: | | COURT | : | PCT./PLAC | E: PE | RMIT #: | | | |
| PHONE: | ON/E | BEFORE | | TA | RG | WT #1 80 | 000 | GVWR #1 jo | |
| ADDRESS: TX | | | | | RG | WT #2 0 | | GVWR #2 c |) |
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| SHIPPING #: C | 05596136 | | CONSIGNOR: | CES ENVIRONM | ENTAL | CONSIGNE | EE: VE | S ENVIRONMEN | ral |
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| TICKET VIOL. CIT | E # Unit! COS COS No. Y/N DIS | | DRIVER:PLEA | SE COMPLY WITH | VIOLATIONS D DIRECTIONS ON | | OF THIS | FORM | |
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| | | | | ER OUT OF SER | | | TI = | | o imiliate |
| or Service" the | nt to authority contain vehicle/s with defect report. No person sh | cs torromed by | "imb" in the U | ut or service | DRIVER Pursua: TRC Chapter 6- declare the d | 44 i nerecy n | courty and | N. Kebat | ositions red at Scene / Oper, Auth. |
| applied to thes | se vehicles or operate | such vehicles | until the out | of service | Out of Service | e. No motor c | arrier sh | all B. Towed. | Escorted to |
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| SEE CONTINUATION | roper operating autho | | | | operate any mo | otor vehicle | untii | U. Unknow | y n |
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| D AND A- YES, WE N SRD INTO PKLOT | SHEET TROOPER ATHER C/D TRAFFIC | rity has been of COMMENTS: MED. VEH FLAG 2 SAFETY INS | GED DOWN FROM | | X TW Seminar COPY RECE | VIVED BY RED BY: G | ARCIA, R | U. Unknow N. Drive | vn : : ocs |

ANY ENTRIES IN THE VIOLATIONS' SECTION OF DRIVER'S COPY, WHERE THERE IS "YES" IN THE TICKET BOX, INDICATES CHARGES FILED AGAINST THE DRIVER THIS WILL REQUIRE CONTACTING THE JUDGE FOR APPROPRIATE DISPOSITION

JUDGE INFORMATION IS IN HEAVY BORDERED BOX ON DRIVER'S COPY

PAYMENTS FOR FINES SHOULD BE SENT TO THE COURT LISTED ON THE DRIVERS COPY.

DO NOT SEND PAYMENTS TO TX DPS/MCB.

CERTIFICATION OF REPAIRMAN

I CERTIFY THAT THE REQUIRED REPAIRS SHOWN IN THE "OUT OF SERVICE" COLUMN ON THE OTHER SIDE OF THIS CERTIFICATE HAVE BEEN SATISFACTORILY COMPLETED

SIGNATURE OF REPAIRMAN NA

NAME OF SHOP (GARAGE)

REPAIR WORK COMPLETED

7-28-2009

DATE TIME

MOTOR CARRIER CERTIFICATION OF ACTION TAKEN

I CERTIFY THAT ALL VIOLATIONS NOTED UPON THIS REPORT HAVE BEEN CORRECTED AND ACTION HAS BEEN TAKEN TO ASSURE COMPLIANCE WITH THE MOTOR CARRIER SAFETY REGULATIONS INSOFAR AS THEY ARE APPLICABLE TO MOTOR CARRIERS AND DRIVERS

HSE Manager

SIGNATURE OF CABRIER OFFICAL

TITLE

DATE

ATTENTION DRIVER

This report must be furnished to the motor carrier whose name appears on this report

ATTENTION DRIVER

TRC Chapter 644, Revised Statutes, requires the Motor Carner to execute the above certification

and return this report to

MOTOR CARRIER BUREAU
TEXAS DEPARTMENT OF PUBLIC SAFETY

PO BOX 4087

AUSTIN TX 78773-0521

IMPORTANT MESSAGES

Any enforcement actions taken against you and any subsequent court actions are intended to secure compliance with the traffic laws and all other users of the highways. Failure to comply with your written promise to appear in court as made on this citation will constitute a separate offense with which you may be charged and result in warrants being issued for your arrest. Failure to appear in court or failure to satisfy a judgement ordering payment of a fine and cost in the manner ordered by the court may result in the denial of renewal of your driver's license.

A second or subsequent conviction of failure to maintain financial responsibility will result in the suspension of your driver's license and motor vehicle registration unless you file and maintain proof of financial responsibility with the Department of Public Safety for two (2) years from the date of conviction. The Department may waive the requirement to file proof of financial responsibility if you file satisfactory evidence with the Department showing that at the time this citation was issued the vehicle was covered by a liability insurance policy or that you were otherwise exempt from the requirements to provide evidence of financial responsibility.

You may be able to require that this charge be dismissed by successfully completing a driving safety course or a motorcycle operator training course. You will lose that right if, on or before your appearance date, you do not provide the court with notice of your request to take the course. This article does not apply to an offense committed by a person who holds a commercial driver's license.

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To obtain IFTA information contact the State of Texas Comptrollers Office at 1-800-252-1383 or visit their website at www.window.state.tx.us/taxinfo/fuels/lifta.html

Citation Number: 04 - A6113720

Date and Time of Offense: 01152009 at 14:26 PM

Defendant:

RODRIGUEZ, BOBBY

DOB: (6)

Driver's License Number:



WWWJP. HCTX. net. \$8500



Offense Title(s): OBSCURED LICENSE PLATE

Location of Offense: 13500 HARDY TOLL ROAD -- Speed Limit: Alleged Speed:

Vehicle: 08 RED TR PTRB License: R88038 State: TX

You are notified to appear at JP Court 4-1 on 05282009 at 09:00 AM to make arrangements to resolve the charges alleged by this citation. THIS IS NOT A TRIAL DATE. Please allow 7 days for processing before attempting to resolve this citation with the court. If you fail to appear in court as provided by law for the prosecution of an offense or if you fail to pay or satisfy a judgment ordering the payment of a fine and cost in the manner ordered by the court you may be denied renewal of your driver's license.

Court Locations: Judge Aclaims

JP 4-1 6831 Cypresswood Dr., Spring, Texas 77379 - Phone (281)376-5512 JP 3-1 14350 Wallisville Rd., Houston, Tx 77015 - Phone (713)450-2409

JP 4-2 7900 Will Clayton Pkwy, Humble, Texas 77338 - Phone (281)446-7191

Deputy: J. ROSE PID Number:04361 Unit Number:84T10

CES ENVIRONMENTAL SERVICES, INC.

4904 GRIGGS ROAD HOUSTON, TEXAS 77021 (713) 676-1460 BANK OF AMERICA, NA 35-2/1130

7/29/2009

PAY TO THE Judge Adams ORDER OF

\$ **85.00

Eighty-Five and 00/100***

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Judge Adams 6831 Cypresswood Dr. Spring, TX 77379 DOLLARS 🗗 🎡

46396

MEMO

Obscured license plate

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CES ENVIRONMENTAL SERVICES, INC.

46396

Judge Adams

7/29/2009 Discount

Date Type

Original Amt. 85,00 Balance Due 85.00 Payment

7/29/2009

Bill

Reference 04-A6113720

Check Amount

85.00 85.00

CES Environmental S Obscured license plate

85.00

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| • TCLP Semi- | Volatiles |
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| TCLP Volatile | es |
| Other Requir | red Forms |
| National Rec | certification Form |
| Other: | The state of the s |
| Additional: Up | odated Waste Analysis Plan, if any. |

If you have already submitted your profile renewal, please disregard this notice. However, if you have any questions regarding the renewal or re-certification process, please contact our Technical service team at 800-WMDisposal or 800-963-4776.

Thank you for your business. Waste Management of Texas

City of Pasadena Municipal Court (713) 475-5562 1001A East Shaw Pasadena, Texas 77506

| Name: | HERNANDEZ, JOSEPH | PATRICK Date of | of Birth: (b) (6) | | <u> </u> |
|--|---|---|---|--|---|
| Case No. Amount: | 1548228 1596310 \$620.00 | | | | PC |
| f the total o | TIME PAYMENT. of fines and costs in full as f | I request time payment o | of the above fines and | costs. I represent | that I am able to pay |
| | | | | | |
| | agree to pay \$150.00 e fines and costs are p | | d the sum of \$1: | 18.00 every 30 | days thereafter |
| | | | .5 | | |
| | | | į. | | |
| | and that a \$25.00 State fee | will be added to each | case for which the fir | ne and costs are n | ot fully paid within |
| ou days o | f the court date. | · · · · · · · · · · · · · · · · · · · | | | |
| 77506 (71 I underst and I mu FAILURI HEREIN SATISFII WILL NO | herwise instructed, I agree 3) 472-6262 not later than and that the agreement the stappear in person to request of the stappear in person to request of the stappear in person to request of the stappear in person to request of the stappear in person to PAY MAY RESULT IN MY COED ACCORDING TO LAVOT CONSTITUTE A MODULATION OR WAIVER OF | at I have made above of uest such modification. OR DISCHARGE THE OF LONGING | ork day following the or can be varied only we E FINES AND COS SUCH TIME AS THE AN AMOUNT THAT VER OF THE TERM NT OF THIS AGR | date I sign this form ith the written appointment of the second of the s | nn. oproval of the court NNER PROVIDED OSTS HAVE BEEN THAT SPECIIFED ODITIONALLY, NO |
| Date: | N 1 8 2009 | · | | Phone # | |
| | | Defendants Signature | ; | | |
| Address | | Printed Name | | | |
| City | Zipcode | ORDE | IR | · | |
| | t, having considered the for granted in accordance with | | | | of the opinion that it |
| Dat ckUN | 8 2009 | | | \$ 1 t | |
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| Date Paid | Amount | Receipt # | Balance | A. A. A. |
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PAYMENT INFORMATION

Monday – Friday 7:45 – 4:45 pm Closed on weekends!

Cash, Credit and Debit Cards (Visa or Master)

<u>Cardholder must be present with ID or DL.</u>

Personal Checks, Money Orders, Cashiers Checks

Make Payable to: <u>City of Pasadena</u>

MAILING ADDRESS:

Pasadena Municipal Court P.O. Box 1575 Pasadena, TX 77501-1575

After hours payment may be placed in the night drop box located to the left of the exit door of the Municipal Court at 1001 East Shaw Ave.

NEVER DEPOSIT CASH

Please write your case/cause #, name, DL or ID#, and DOB on all Money Orders or Cashiers Checks.

To avoid any penalties, mail payments at least 5 days before due date

INFORMACION DE PAGO

Lunes – Viernes 7:45 am – 4:45 pm Cerrado los fines de semana!

Dinero en efectivo, tarjetas de credito y debito (Visa O Master)

<u>Del titular de la tarjeta debe estar presente con su indetificacion</u>.

Cheques personales, giros postales, cheques de gerencia.

Haga el Pago a: <u>City of Pasadena</u>

ENVIO DE DIRECCION

Pasadena Municipal Court P.O. Box 1575 Pasadena, TX 77501-1575

Fuera de horario el pago puede ser colocado en la caja de buson Localizada a la izquierda de la puerta de salida de la Corte Municipal de 1001 East Shaw Ave.

NUNCA DEPOSITE DINERO EFECTIVO

Por favor escriba su numero e su caso/causa#, nombre, DL or ID#, y fecha de nacimiento en todos los Giros Postales o Cheques de Gerencia.

*Para evitar cualquier multa, envie su pagos al menos 5 dias antes de vencimiento

| CITY OF HOUSTON MUNICIPAL COUL 1400 Lubbook 1 8300 Mykawa 3203 S. Dain A Houston, TX 77002-1556 Houston, TX 77048 100 AM to 1900 PM. Bood M. to 500 PM. Boo | shord one incations see page 4, call 311 or () one incations see page 4, call 311 or () one incations see page 4. Court # 11 Time 300 AM /# | r court date or YOU MUST APPEAR 13) 837-0311, or visit www.houstoncourts.org P Date: 9 / 27 / Sear | Toke # 1 | 17583024 |
|--|---|--|--|--|
| BOOAM is 500 Pt. Closed 12 PM - 1 PM ast BEENAN | First Name | MLD W | DID CDL (b) (6) | st 🎉 |
| ad 5 ₈ DDB 7 / / / 50 dame (b) (6) ddress | Heiding Velto (b) | (6) ST Cold (1) Ma | ke Ciwol Model 72. (6) (b) (6) Hor | Occ Occ Fron Back |
| /ork ddress | City | ST ZIP | Area Wol Code Pho | |
| #1 Speeding Construction zone Workers p #2 Ran Red Light I Stop line Crossw #3 Ran Stop Sign G Stop line Crossw | ne Time from: 10. | Locations/ | O LOOK FU XX XX, FUT | 1 200 |
| #4 No DL CI Exorection: | ### D Adult Passenger DChild (0.4) See | Accident Report # | | |
| **Midlate restriction W/count Lev | #7 D No Registration | _1. | athCCL Traffic MOD | Road OFF |
| , □ No CDL: ☐ No Motorcycle Endocsement ☐ Falled to notify address change | #8 Failure to establish Financial Responsibility (No Insurance) II fst Offense on: | ÖFFENSE DATE Morth / Day / | Year (issue date if different) | SEARCH Y/ CONSENT Y/ ARREST Y/ |
| N FAIL TO MAINTA | Agency:County | OFFICER S | Year | |
| ⊭10 □ | | Your failure to appear, failure to | pay, or failure to satisfy a judg | ment ordering payme |
| Notes / Witness name; address, phone / Witness name ar | d ID# | of a fine and costs, may result in: 1 to Appear and \$212 fine; 3) denis registration of renewal; and 5) a \$ admission of guilt, but I do ackriat the time and place designated ticket. | of Driver's License renewal; 4 30 DPS fee for each violation of swiedge receipt of this notice a |) denial of motor vehic harged. This is <u>not</u> not will appear in co |

| TX091S0EDE01 | TXDPS COMMERCIAL VEHICLE ENF | ORCEMENT CD# . 01 E1 | O10 |
|--|--|--|--|
| ☐ ARREST TKT ☐ 9 - 15 PASS. FOR HIRE | | CP#: 0151 | 818 1 |
| ☑ COM. VEH. ☐ 16 PASS. FOR HIRE | an brook Timenomane | RUCTION ZONE FIXED ROADSI | DE ALCH DS |
| ACCIDENT 16 PASS. NOT FOR HIRE CDL SCHEDULE CHARTER | SP PROG: ☑ INTERSTATE ☐ : | YES MO SCALE DCCUPIED HOUSE 2A501 | ☑ SW ☐ TE |
| DATE: 03/05/2009 TIME: 9:15 AM | | (1) IH-0010 IN CHAMBERS CO. (797- | - |
| Lessee/MC: | | USDOT# | |
| Add/City/St/Zip: | | ICC/MC | #: 400234 |
| OWNER: CES ENVIRONMENTAL SERVICES | INC | TXDOT# | : 005516524C |
| ADD/CITY/ST/ZIP:4904 GRIGGS ROAD HOUSTON, I | x 77021 | PHONE# | : 7136761460 |
| Operator: JOSEPH PATRICK HERNANDEZ | RACE/SEX: | UM DOB: _(b) (6) MED CA | .RD: |
| Add/City/St/Zip: (b) (6) | | DL #: <mark>(b) (6)</mark> ST: T | X DL CLASS: A |
| VEH SEARCH: ☐ YES ☑ NO REASON FOR | STOP: WARN CITATION | INSPECTION CONTRABAND LOCATED: | YES MO |
| TYPE OF SEARCH: CONSENT PC INC. TO | ARREST INVENTORY TYPE OF CON | TRABAND: DRUGS WEAPONS DC | CURRENCY DOTHER |
| Improvemental and a second sec | MAKE CO# Plate Stat V | A representation of the second | |
| 1/2. 00 1/2 ST | | 3E4D1173F515012 /GN4025YB020957 | |
| X Soffense 2 ST | TA 177 | 0.1402310020337 | |
| _ | | 1/1 Far (14 Mei 14 Mei | |
| SIGNATURE: I HEREBY PROMISE TO APPEAR AT THE TIME AN | | | |
| PLACE DESIGNATED IN THIS NOTICE. (THIS IS NOT A PLEA OF GUILTY) | X(6640)~-0(1004 | 0)00(17080) | |
| OPY RECEIVED BY | GROSS WEIGHT: 33,7 | 760 GROUP WEIGHT: | 0 |
| YOU ARE HEREBY NOTIFIED TO APPEAR | | LOAD DISP: | |
| JUDGE: COU | RT: PCT./PLACE: | PERMIT #: | |
| PHONE: ON/BEFORE | AT | | ĪR #1] |
| ADDRESS: TX | | RG WT #2 24000 GVW | 7R #2 |
| SEAL #'S REMOVED: DEPT. SEAL #; INS | ALLED CVSA DECAL-TT CVS | A DECAL-ST CVSA DECAL-ST | |
| | | ! | |
| SHIPPING #: NONE | CONSIGNOR: CES ENVIROMENTAL | CONSIGNEE: CES ENVI | ROMENTAL |
| COMMODITY: OIL FIELD EQIPMENT | ORIGIN: HOUSTON | TX DESTINATION: PORT AUF | THOR TX |
| - | PLACARDS REQ? HYD HYD ELEC | <u></u> | D SPEED |
| NA | | SPEED | |
| | SPEC. TANK AX 1 AX 2 AX 3 | AX 4 AX 5 AX 6 AX 7 AX 8 RADAR | CAL. |
| | I HAD WEELE | | |
| TICKET VIOL. CITE # Unit OOS OOS POST No. Y/N DISP ACC | VIOL DRIVER:PLEASE COMPLY WITH DIRECT | ATIONS DISCOVERED | |
| | S NOT PROTECTED IN CASE OF BREAKAW | | ick |
| 1 SMOK | ng vehicle (10 seconds or more) - E | XCESSIVE SMOKE | |
| 393.95(c) 1 NO SI | ARE FUSES - NONE | | |
| 393.95(a) 2 FIRE | EXTINGUISHER VIOLATION - NONE | | |
| 391.45(b) D EXPI | ED MEDICAL EXAMINERS CERTIFICATE - | 3/3/09 | |
| | | | / |
| | | | |
| | VEHICLE/DRIVER OUT OF SERVICE I | NOTICE | |
| VEHICLE Pursuant to authority contained in TRC CF of Service" the vehicle/s with defects followed k | apter 644 I hereby declare "Out DRIV | ER Pursuant to authority contained in Chapter 644 I hereby notify and | OOS DISPOSITIONS |
| column of this report. No person shall remove the applied to these vehicles or operate such vehicle | e out of service stickers decl | are the driver named on this report | A. Repaired at Scene / Obtained Oper. Auth. B. Towed/Escorted to |
| defects have been repaired and the vehicles have condition, or proper operating authority has been | been restored to safe operating . perm | it or require driver to drive or | Repair Service |
| SEE CONTINUATION SHEET TROOPER COMMENTS: | | | U. Unknown N. Driver OOS |
| T-Y VIN OSS | | | ! |
| | | | |
| | X | Colfunder | Log Book Exemption |
| | <u> </u> | OPY RECEIVED BY | ✓ Log Book Exemption |
| (| CONTRICT/AREA FIME COMPLETED REPO | OPY RECEIVED BY | ✓ Log Book Exemption |

JUDGE INFORMATION IS IN HEAVY BORDERED BOX ON DRIVER'S COPY.

PAYMENTS FOR FINES SHOULD BE SENT TO THE COURT LISTED ON THE DRIVER'S COPY.

DO NOT SEND PAYMENTS TO TX DPS/MCB.

| CERTIFICATION OF REPAIRMAN I CERTIFY THAT THE REQUIRED REPAIRS SHOWN IN THE "OUT OF SERVICE" COLUMN ON THE OTHER SIDE OF THIS CERTIFICATE HAVE BEEN SATISFACTORILY COMPLETED. | | | | | | | | |
|---|------------------------|------------|-------------|--|--|--|--|--|
| SIGNATURE OF REPAIRMAN: | NAME OF SHOP (GARAGE): | REPAIR WOR | K COMPLETED | | | | | |
| | | DATE: | TIME: | | | | | |
| MOTOR CARRIER CERTIFICATION OF ACTION TAKEN I CERTIFY THAT ALL VIOLATIONS NOTED UPON THIS REPORT HAVE BEEN CORRECTED AND ACTION HAS BEEN TAKEN TO ASSURE COMPLIANCE WITH THE MOTOR CARRIER SAFETY REGULATIONS INSOFAR AS THEY ARE APPLICABLE TO MOTOR CARRIERS AND DRIVERS. | | | | | | | | |
| SIGNATURE OF CARRIER OFFICIAL: | TITLE: | DATE: | | | | | | |

ATTENTION DRIVER:

This report must be furnished to the motor carrier whose name appears on this report.

ATTENTION DRIVER:

TRC Chapter 644, Revised Statutes, requires the Motor Carrier to execute the above certification

and return this report to:

MOTOR CARRIER BUREAU TEXAS DEPARTMENT OF PUBLIC SAFETY

PO BOX 4087

AUSTIN TX 78773-0521

IMPORTANT MESSAGES

Any enforcement actions taken against you and any subsequent court actions are intended to secure compliance with the traffic laws and all other users of the highways. Failure to comply with your written promise to appear in court as made on this citation will constitute a separate offense with which you may be charged and result in warrants being issued for your arrest. Failure to appear in court or failure to satisfy a judgement ordering payment of a fine and cost in the manner ordered by the court may result in the denial of renewal of your driver's license.

"A second or subsequent conviction of failure to maintain financial responsibility will result in the suspension of your driver license and motor vehicle registration unless you file and maintain proof of financial responsibility with the Department of Public Safety for two (2) years from the date of conviction. The Department may waive the requirements to file proof of financial responsibility if you file satisfactory evidence with the Department showing that at the time this citation was issued the vehicle was covered by a liability insurance policy or that you were otherwise exempt from the requirements to provide evidence of financial responsibility.

You may be able to require that this charge be dismissed by successfully completing a driving safety course or a motorcycle operator training course. You will lose that right if, on or before your appearance date, you do not provide the court with notice of your request to take the course. This article does not apply to an offense committed by a person who holds a commercial driver's license.

"A conviction of an offense under a traffic law of this state or a political subdivision of this state may result in the assessment on your driver's license of a surcharge under the Driver Responsibility Program."

A request for an out-of-service review, regarding operating authority, must be made in writing and forwarded to the manager of the Motor Carrier Bureau. If requested, a review will be scheduled and conducted by the manager of the Motor Carrier Bureau or the director's designee within 10 days of the issuance of the out-of-service order. A request for review should be addressed to the Texas Department of Public Safety, Motor Carrier Bureau, P.O. Box 4087, Austin, TX 78773-0521 or may be sent by facsimile transmission to (512) 424-5712 or via electronic mail at MotorCarrierBureau@txdps.state.tx.us. The Department may conduct the review by telephone conference call.

To obtain a TxDOT Motor Carrier Insurance Certificate or Single State Registration - contact the Texas Department of Transportation at 1-800-299-1700 or visit their website at www.dot.state.tx.us.

To obtain a USDOT Number contact the Federal Motor Carrier Safety Administration at 1-800-832-5660 or visit their website at www.fmcsa.dot.gov/factsfigs/formspubs.htm.

To obtain IFTA information contact the State of Texas Comptrollers Office at 1-800-252-1383 or visit their website at www.window.state.tx.us/taxinfo/fuels/ifta.html.

| TX094B0EDS05 | TXDPS COMMERCIAL VEHICLE ENFORCEMENT | LEVEL |
|--|---|---|
| ARREST TKT 7 9 - 15 PASS. FOR HIRE | CP#: 015 | 51818 2 |
| ☐ COM. VEH. ☐ 16 PASS. FOR HIRE ☐ ACCIDENT ☐ 16 PASS. NOT FOR HIRE | SP PROG: INTERSTATE YES MY NO SCALE | ADSIDE ALCH DS |
| CHARTER | INTRASTATE OCCUPIED HOUSE 2A502 | ✓ SW 🗖 TE |
| DATE: 06/04/2009 TIME: 7:30PM Lessee/MC: | COUNTY: CHAMBERS HWY: (1) IH-0010 IN CHAMBERS CO. (| |
| Add/City/St/Zip: | 100 | ************************************** |
| OWNER: CES ENVIRONMENTAL SERVICES | | ************************************** |
| ADD/CITY/ST/ZIP:4904 GRIGGS ROAD HOUSTON, T | ¥ 77001 | ONE#: 7136761460 |
| Operator: IRVIN LYNN WOODARD | | CARD: 7-3-09 |
| Add/City/st/Zip; (b) (6) | DL # | TX DL CLASS: A |
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| NOT A PLEA OF GUILTY) | X(16600)00(38600) | |
| COPY RECEIVED BY | GROSS WEIGHT: 55,200 GROUP WEIGHT: | 0 |
| YOU ARE HEREBY NOTIFIED TO APPEAR | LOAD DISP: | |
| JUDGE: RANDALL VANDEVENTER COU | RT:JP PCT./PLACE: 2/1 PERMIT #: | |
| PHONE: (409) 267-8249 ON/BEFORE Fri, | 19-June-2009 AT 04:00:00PM RG WT #1 66000 | GVWR #1 |
| ADDRESS: P. O. BOX 971 ANAHUAC TX 77514 | RG WT #2 | GVWR #2 |
| SEAL #'S REMOVED: DEPT. SEAL #: INST | ALLED CVSA DECAL-TT CVSA DECAL-ST CVSA DECAL-ST | |
| | <u> </u> | <u> </u> |
| SHIPPING #: 87167 | CONSIGNOR: KMTEX CONSIGNEE: CES | |
| COMMODITY: RECYCLABLE HYDROCARBONS | ORIGIN: PORT ARTHUR TX DESTINATION: HOUST | ON TX |
| | 7? PLACARDS REQ? ALL | EGED SPEED |
| . NA | SPEC. TANK AX 1 AX 2 AX 3 AX 4 AX 5 AX 6 AX 7 AX 8 NAD | ED LIMIT |
| | SPEC. TANK | AR CAL. |
| TICKET VIOL. CITE #[Unit] OOS OOS POST | VIOLATIONS DISCOVERED | <u> </u> |
| No. Y/N DISP ACC | DRIVER:PLEASE COMPLY WITH DIRECTIONS ON BACK SIDE OF THIS FORM | 1 |
| 163 2 | 34,000 LBS. TANDEM AXLE - 38600/34000=4200 OVER | |
| | TO DISPLAY LICENSE RECEIPT (COMMERCIAL MOTOR VEHICLE) - | |
| i i i Dižen | AV PVNTPPN FTPPNPP NTAMP (#1 . | * |
| | AY EXPIRED LICENSE PLATE (#) - | |
| | AY EXPIRED LICENSE PLATE (#) - ED CMV INSPECTION CERTIFICATE / ANNUAL DOT - | |
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| 396.17(c) 1 EXPIR | ED CMV INSPECTION CERTIFICATE / ANNUAL DOT - VEHICLE/DRIVER OUT OF SERVICE NOTICE apter 644 I hereby declare "Out DRIVER Pursuant to authority contained : | ir. Jos DISPOSÍTIONS |
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| DATE: 06/04/2009 TIME: | | _ | N CHAMBERS CO. (797- | |
| Lessee/MC: | | | USDOT | |
| Add/City/St/Zip: | | | | |
| OWNER: CES ENVIRONMENTAL | SERVICES INC | | TXDQXT | |
| ADD/CITY/ST/ZIP:4904 GRIGGS ROAD | HOUSTON, TX 77021 | | PHONE | |
| Operator: IRVIN LYNN WOODAR | D RV | ACE/SEX: WM DOB: | (1.) | RD: 7-3-09 |
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| VEH SEARCH: YES MO | REASON FOR STOP: WARN CITA | ATIONINSPECTION | CONTRABAND LOCATED: | : □YES ☑NO |
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| PLACE DESIGNATED IN THIS NOTICE. NOT A PLEA OF GUILTY) | (THIS IS X (16600) | 00 (38600) | | |
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| YOU ARE HEREBY NOTIFIED TO APPEAR | | LOAD DÍ | SP: | |
| JUDGE: RANDALL VANDEVENTER | COURT: JP PCT./ | PLACE: 2/1 PERMIT | # : - | |
| PHONE: (409) 267-8249 ON/BE | FORE Fri, 19-June-2009 AT 0 | 4:00:00PM RG WT # | 1 66000 GVW | R #1 |
| ADDRESS: P. O. BOX 971 ANAHUAC TX 7 | 7514 | RG WT # | 2 ĞVW | ĪR #2 |
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| TICKET VIOL, CITE # Unit OOS OOS | ' | VIOLATIONS DISCOVI | | i . |
| Yes 1 | OVER 34,000 LBS. TANDEM AX | ITH DIRECTIONS ON BACK LE - 38600/34000=4200 | | |
| Yes 1 | FAIL TO DISPLAY LICENSE RECEIF | | | · · · · · · · · · · · · · · · · · · · |
| 1 | r i | | | |
| 1-T | DISPLAY EXPIRED LICENSE PLATE | (#) - | | |
| 1 | DISPLAY EXPIRED LICENSE PLATE EXPIRED CMV INSPECTION CERTIFI | | | |
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| 1 | | CATE / ANNUAL DOT - | | |
| 396.17(c) 1 Total Control of the state of | EXPIRED CMV INSPECTION CERTIFI VEHICLE/DRIVER OUT OF d in TRC Chapter 644 I hereby declare 40 | SERVICE NOTICE | ethority contained in | oos dispositions |
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| PMC 08- 604740 | | PASADENA MUNICIPA | AL COURT | Reset |
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| Step Site Sup Employee # | | | uction Zone | Workers Accident Y |
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| (b) (6) Regisfration | Year Reg State | Vehicle Year Vehicle Make | Vehicle Model | Vehicle Type Vehicle Co |
| Speeding OFFICER'S A | ─ 10□ - | 2 5a | | - Zmesh |
| □Ran Red tight □Ran Stop Sign 1/17, Contraction | | of Violation # | stra 127 | Direction Direction |
| □No Driver's License (1)(1)(1) □Financial Rosponsibility (No Insurance | Y N Court D | late: 3-26 | Time: | 2 |
| □Failed to Yield ROW □No MVI Sticker Expired | appear | in court at 1001 Shaw Ave | | tice and will pay the fine(s) or the time indicated and thereafter, |
| □No Vehicle Registration Expired □Adylt Safety Belt □Driver □ Passen | ger / | 1/2- | J. J. J. J. C | 4 |
| Weather Treffic Road S ☐Clear ☐Warm ☐Light ☐Dry ☐Cloudy ☐Cold ☐Moderate ☐Wet ☐Rain ☐ ☐ ☐Heavy ☐ | Officer | 1125 | | Employee# |
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| Lessee/MC: CES ENVIRONMENTAL SERVICES 1 | | IN CHAMBERS CO. (797-831) MP#: 815 |
| 1001 001000 0010 0010 | | USDOT#: 869392 |
| The state of the s | | ICC/MC#: 400234 |
| OWNER: CES ENVIRONMENTAL SERVICES 3 | And the state of t | TXDOT#: 005516524C |
| ADD/CITY/ST/ZIP:4904 GRIGGS ROAD HOUSTON, TO Operator: CHARLES B SITTIG | RACE/SEX: WM DOB: | PHONE#: 7136761450 |
| | and the second s | MED CARD: 2/7/10 |
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| PHONE: (409) 267-8249 ON/BEFORE Thu, 2 | | #: |
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| SHIPPING #: 82435 | CONSIGNOR: CES ENVIRONMENTAL SERVICES CO | |
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JUDGE INFORMATION IS IN HEAVY BORDERED BOX ON DRIVER'S COPY.

PAYMENTS FOR FINES SHOULD BE SENT TO THE COURT LISTED ON THE DRIVER'S COPY.

DO NOT SEND PAYMENTS TO TX DPS/MCB.

CERTIFICATION OF REPAIRMAN

TCERTIFY THAT THE REQUIRED REPAIRS SHOWN IN THE "OUT OF SERVICE" COLUMN ON THE OTHER SIDE OF THIS CERTIFICATE HAVE BEEN SATISFACTORILY COMPLETED.

SIGNATURE OF REPAIRMAN: NAME OF SHOP (GARAGE): REPAIR WORK COMPLETED

DATE: TIME: 7 Am.

PACES 5160 3-6-09 7 Am.

MOTOR CARRIER CERTIFICATION OF ACTION TAKEN I CERTIFY THAT ALL VIOLATIONS NOTED UPON THIS REPORT HAVE BEEN CORRECTED AND ACTION HAS BEEN TAKEN TO ASSURE COMPLIANCE WITH THE MOTOR CARRIER SAFETY REGULATIONS INSOFAR AS THEY ARE APPLICABLE TO MOTOR CARRIERS AND DRIVERS.

SIGNATURE OF CARRIER OFFICIAL: TITLE: DATE

ATTENTION DRIVER: This report must be furnished to the motor carrier whose name appears on this report.

ATTENTION DRIVER:

TRC Chapter 644, Revised Statutes, requires the Motor Carrier to execute the above certification

and return this report to: MOTOR CARRIER BUREAU

TEXAS DEPARTMENT OF PUBLIC SAFETY

PO BOX 4087 AUSTIN TX 78773-0521

IMPORTANT MESSAGES

Any enforcement actions taken against you and any subsequent court actions are intended to secure compliance with the traffic laws and all other users of the highways. Failure to comply with your written promise to appear in court as made on this citation will constitute a separate offense with which you may be charged and result in warrants being issued for your arrest. Failure to appear in court or failure to satisfy a judgement ordering payment of a fine and cost in the manner ordered by the court may result in the denial of renewal of your driver's license.

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| Add/City/St/Zip: 4904 GRIGGS ROAD HOUST | | | | USDOT#: | 869392 |
| OWNER: CES ENVIRONMENTAL SERV | ICES INC | | | TXDOT#: | 400234 005516524C |
| ADD/CITY/ST/ZIP:4904 GRIGGS ROAD HOUST | ON, TX 77021 | | · · · · · · · · · · · · · · · · · · · | PHONE#: | 7136761460 |
| Operator: CHARLES B SITTIG | | RACE/SEX: WM | DOB: _(b) (6) | MED CARD: | |
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| 396.5(b) 1 | OIL/GREASE LEAK - HYDRA | AULIC OIL LEAK ON REAR | CAB AREA | | |
| 393.83(a) 1 | EXHAUST SYSTEM LOCATION | N - EXHAUST PIPE RUBBIN | NG ON HYDRAULIC L | INES ON REAR OF | CAB |
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JUDGE INFORMATION IS IN HEAVY BORDERED BOX ON DRIVER'S COPY.

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SIGNATURE OF CARRIER OFFICIAL: TITLE: DATE:

1 Section 21/2 A HSE Manager 3-6-09

ATTENTION DRIVER:

This report must be furnished to the motor carrier whose name appears on this report.

ATTENTION DRIVER:

TRC Chapter 644, Revised Statutes, requires the Motor Carrier to execute the above certification

and return this report to:

THEY ARE APPLICABLE TO MOTOR CARRIERS AND DRIVERS.

MOTOR CARRIER BUREAU TEXAS DEPARTMENT OF PUBLIC SAFETY

PO BOX 4087

AUSTIN TX 78773-0521

IMPORTANT MESSAGES

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| OWNER: CES ENVIRONMENTAL SERVICES INC | | TXDOT#: 005516524C |
| ADD/CITY/ST/ZIP: 4904 GRIGGS ROAD HOUSTON TY | 77021 | PHONE#: 7136761460 |
| OPERATOR: PRESTON SANDERS | RACE/SEX: BM DOB: | _(b) (6) MED CARD: 04/18/2010 |
| ADD/CITY/ST/ZIP: (b) (6) | DL #: 0 | USTON ST: TX DL CLASS: A |
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| V | EHICLE/DRIVER OUT OF SERVICE NOTICE | |
| UPHICLE Pursuant to authority contained in TRC Chap of Service" the vehicle/s with defects followed by | 165 IN the out of Service IRC chapter 944 | to authority contained in OOS DISPOSITIONS I hereby notify and N. Repaired at Scene / |
| column of this report. No person shall remove the applied to these vehicles or operate such vehicles | out of service stickers declare the drivential the out of service. Out of Service. | er named on this report Obtained Oper. Auth. No motor carrier shall B. Towed/Escorted to |
| defects have been repaired and the vehicles have be condition, or proper operating authority has been o | n restored to safe operating permit or requir cperate any moto | e driver to drive or Repair Service r vehicle until D. Other U. Unknown |
| SEE CONTINUATION SHEET TROOPER COMMENTS: D AND A TESTING (YES) NO VIOLATIONS, GOOD JOB | VIIN # 1- | N. Driver GOS |
| (b) (6) vin # 2- (b) (6) | V | l i |
| | X | Log Book Exemption |
| INSPECTED BY: ID/REGION/D | STRICT/AREA FIME COMPLETED REPORT PREFAREI | |
| PERRIN, TARRENCE C. 2V-0715 | 18 2 9 V 8:09AM REFERRAL ID | |
| CHARGES FILED BY: | BRAKES INSPECTI | D BY: 2V-071518 |

ANY ENTRIES IN THE VIOLATIONS' SECTION OF DRIVER'S COPY, WHERE THERE IS "YES" IN THE TICKET BOX, INDICATES CHARGES FILED AGAINST THE DRIVER. THIS WILL REQUIRE CONTACTING THE JUDGE FOR APPROPRIATE DISPOSITION. JUDGE INFORMATION IS IN HEAVY BORDERED BOX ON DRIVER'S COPY. PAYMENTS FOR FINES SHOULD BE SENT TO THE COURT LISTED ON THE DRIVERS COPY, DO NOT SEND PAYMENTS TO TX DPS/MCB. CERTIFICATION OF REPAIRMAN I CERTIFY THAT THE REQUIRED REPAIRS SHOWN IN THE "OUT OF SERVICE" COLUMN ON THE OTHER SIDE OF THIS CERTIFICATE HAVE BEEN SATISFACTORILY COMPLETED. NAME OF SHOP (GARAGE): REPAIR WORK COMPLETED SIGNATURE OF REPAIRMAN: TIME DATE MOTOR CARRIER CERTIFICATION OF ACTION TAKEN I CERTIFY THAT ALL VIOLATIONS NOTED UPON THIS REPORT HAVE BEEN CORRECTED AND ACTION HAS BEEN TAKEN TO ASSURE COMPLIANCE WITH THE MOTOR CARRIER SAFETY REGULATIONS INSOFAR AS THEY ARE APPLICABLE TO MOTOR CARRIERS AND DRIVERS. SIGNATURE OF CARRIER OFFICAL: TITLE: SE Manager ATTENTION DRIVER: This report must be furnished to the motor carrier whose name appears on this report. ATTENTION DRIVER: TRC Chapter 644, Revised Statutes, requires the Motor Carrier to execute the above

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PO BOX 4087

AUSTIN TX 78773-0521

TEXAS DEPARTMENT OF PUBLIC SAFETY

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A request for an out-of-service review, regarding operating authority, must be made in writing and forwarded to the manager of the Motor Carrier Bureau. If requested, a review will be scheduled and conducted by the manager of the Motor Carrier Bureau or the director's designee within 10 days of the issuance of the out-of-service order. A request for review should be addressed to the Texas Department of Public Safety, Motor Carrier Bureau, P.O. Box 4087, Austin, TX 78773-0521 or may be sent by facsimile transmission to (512)424-5712 or via electronic mail at MotorCarrierBureau@txdps.state.tx.us. The Department may conduct the review by telephone conference call.

To obtain a TXDOT Motor Carrier Insurance Certificate or Single State Registration - contact the Texas Department of Transportation at 1-800-299-1700 or visit their website at www.dot.state.tx.us.

To obtain a USDOT Number contact the Federal Motor Carrier Safety Administration at 1-800-832-5660 or visit their website at www.fmcsa.dot.gov/factsfigs/formspubs.htm.

To obtain IFTA information contact the State of Texas Comptrollers Office at 1-800-252-1383 or visit their website at www.window.state.tx.us/taxinfo/fuels/ifta.html.

CVE-3 (Rev. 01/04)

| ś | | | | |
|--|---|--|--|---------------------------------------|
| - | | CITIZEN COPY | | |
| CITY OF HOUSTON MUNICIPAL COURTS | Pay or Resolve this ticket before your | court date or YOU MUST APPEAR | ************************************** | 70704E |
| 1400 Lubbock B300 Mykawa 3203 S. Dairy Ashfor Houston, TX 77002-1556 Houston, TX 77048 Houston, TX 77082 | For other locations \$\frac{\pi}{2}\text{page 4, call 311 or (713)} | 3) 837-0311, or visit www.houstoncourts.org | Ticket# 119 | 797815 |
| Houston, TX 77002-1556 Houston, TX 77048 Houston, TX 77082 7:00 A.M. to 10:00 P.M. 8:00 A.M. to 5:00 P.M. 8:00 A.M. to 6:00 P.M. Monday - Saturday Monday - Friday Mondays and Fridays | Court# / Time / AMCPM | Date 17 / 1 / E 9 | | |
| HPD North Command* 8:00 A.M. to 9:00 P.M. 9455 W. Montpomery Rd: Tuesday - Thursday | | Month / Day / Year | | #1 [9 #] ## #1 ## |
| Monday - Friday 8:00 A.M. to 5:00 P.M. Cigspd 12 P.M T.R.M. | First | · · | | |
| Name / / / / / / / / / / / / / / / / / / / | Name park | MI STANDER MI | | ST |
| Race 3 Sex 7,008 (b) (4) | Veh スタータ | ST Z Color Color Mal | Model Control | Occ Occ |
| Home Address (b) (4) | | | Area Home Code 7 7 7 Phon | 0) (4) |
| Work Address | City | ST SIP | Area Work Phone | |
| #1 Speeding Construction zone Workers present | ent □ School zone □ Sign □ Flashing beacon | | And the second s | |
| MPH in aMPH zone | Time from: to: | # # 8 7 30 5,0 3 | and the second of the second o | · · · · · · · · · · · · · · · · · · · |
| #2 Ran Red Light Stop line Crosswalk | #5 No Seat Belt Gomm, Veh. | # | <u>, f</u> | |
| #3 □Ran Stop Sign □ Stop line □ Crosswalk | ☐ Driver ☐ Juvenike (5-16) ☐ Adult Passenger ☐ ☐ Child (0-4) Seat | 1# | | |
| #4 □ No DL | #6 No Inspection | 1 | | |
| ☐ Expired on:// | Expired on: | Accident Report # | | |
| □ Violate restriction | #7 In No Registration In No Front Plate | If commercial (vehicle, learners permit) incluing Commercial | re SSN Ro | pad ,-" |
| code to wit: | ☐ Expired on:/ | Commercial Y / N HAZMAT Y / N Wes | | rfacé |
| □ No CDL | #8 - Failure to establish Financial Responsibility (No Insurance) | OFFENSE DATE (2) / (2) / (2) | TIME S A.M./P.M. | CONSENT Y/N |
| □ No Motorcycle Endersement | ☐ 1st Offense on:// | / / / | (issue date if different) | ARREST Y/N |
| □ Failed to notify address change | Agency: County | Month Day | Year (asua date ii dinerent) | |
| #9-11 FALL TO FLENING | 6 Para State Contract | OFFICER NAME | | |
| #10 | | Your failure to appear, failure to p of a fine and costs, may result in: 1) | pay, or failure to satisfy a judgmen | t ordering payment |
| Notes / Witness name, address, phone / Witness name and ID | # 1 M Institute I I | to Appear and \$212 fine; 3) denial registration of renewal; and 5) a \$3 | of Driver's License renewal; 4) der | nial of motor vehicle |
| The state of the s | | admission of guilt, but I do acknow | wledge receipt of this notice and ! | will appear in court |
| | | at the time and place designated a ticket. | above. I am the person named ar | nd identified in this |
| | | Signature 2 | | essi Anglesia Anglesia |
| REVISED 1/2008 | e de la companya de la companya de la companya de la companya de la companya de la companya de la companya de | Carrie Brane Barre | Color | |



Houston Municipal Courts

Municipal Courts Administration Department

CITY OF HOUSTON MUNICIPAL COURT 1400 LUBBOCK HOUSTON, TX 77002

T. (713)837-0311 F. (713)247-5210 www.houstontx.gov/courts



Order of Dismissal

CAUSE NUMBER: 2008 TR 0750971

THE STATE OF TEXAS VS.

DONALD BOZEMAN

IN THE MUNICIPAL COURT COURT NO. 12 (LUBBOCK) HOUSTON, HARRIS COUNTY TEXAS

ON THIS DAY THE ABOVE ENTITLED AND NUMBERED CAUSE FOR THE OFFENSE OF FAIL TO DRIVE IN DESIGNATED LANE (SINGLE BLOCK), WAS BEFORE THE COURT. THE COURT HAVING CONSIDERED THE MOTIONS OF THE PARTIES, HEREBY ORDERS THAT THIS CAUSE BE DISMISSED FOR THE FOLLOWING REASON; CASE DISMISSED-OFFICER NOT PRESENT

February 13, 2009

JUDGE, MUNICIPAL COURTS

HOUSTON, TEXAS



Houston Municipal Courts

Municipal Courts Administration Department

CITY OF HOUSTON MUNICIPAL COURT 1400 LUBBOCK HOUSTON, TX 77002

T. (713)837-0311 F. (713)247-5210 www.houstontx.gov/courts

Order of Dismissal

CAUSE NUMBER: 2008 TR 0750962

THE STATE OF TEXAS VS. DONALD BOZEMAN

IN THE MUNICIPAL COURT COURT NO. 12 (LUBBOCK) HOUSTON, HARRIS COUNTY TEXAS

ON THIS DAY THE ABOVE ENTITLED AND NUMBERED CAUSE FOR THE OFFENSE OF SPEEDING (DISTANCE BETWEEN BLOCKS), WAS BEFORE THE COURT. THE COURT HAVING CONSIDERED THE MOTIONS OF THE PARTIES, HEREBY ORDERS THAT THIS CAUSE BE DISMISSED FOR THE FOLLOWING REASON; CASE DISMISSED-OFFICER NOT PRESENT

February 13, 2009

JUDGE, MUNICIPAL COURTS HOUSTON, TEXAS



Houston Municipal Courts

Municipal Courts Administration Department

CITY OF HOUSTON MUNICIPAL COURT 1400 LUBBOCK HOUSTON, TX 77002

T. (713)837-0311 F. (713)247-5210 www.houstontx.gov/courts

Order of Dismissal

CAUSE NUMBER: 2008 TR 0750964

THE STATE OF TEXAS VS.

DONALD BOZEMAN

IN THE MUNICIPAL COURT COURT NO. 12 (LUBBOCK) HOUSTON, HARRIS COUNTY TEXAS

ON THIS DAY THE ABOVE ENTITLED AND NUMBERED CAUSE FOR THE OFFENSE OF OPERATING MOTOR VEHICLE IN VIOLATION OF RESTRICTION CODE A ON DRIVERS LICENSE, WAS BEFORE THE COURT. THE COURT HAVING CONSIDERED THE MOTIONS OF THE PARTIES, HEREBY ORDERS THAT THIS CAUSE BE DISMISSED FOR THE FOLLOWING REASON; CASE DISMISSED-OFFICER NOT PRESENT

February 13, 2009

JUDGE, MUNICIPAL COURTS HOUSTON, TEXAS 456-791-6462

Texas Department of Public Safety THP6# TX089K0EKA004

| Date: December 9, 2008, 3,14 pm DL#TX (4) | |
|--|--|
| Violator: SOTO, ANDRES | and the second |
| Res Addr (b) (4) | Phone: |
| Race/Sex. WM Height 506 DOB (b) (4) | |
| C D L.:☑ Com Veh. ☐ Interstate, ☐ Intrast Owner/Lessee: SOTO,ANDRES Bus Ph# | ate 🖸 |
| Veh LP.TX (b) (4) Make: FORD Mod | el Fi5 |
| Passengers: Passengers: Year 2002 Col HazMat Plac: Type PICKUP TRUCK / EL CA | or TAN/BEIGE |
| Constr Zone: Route 0059 County, WEI | минс. ВВ |
| Workers Present ☐ MIePost: 816 Weather CLE Location: Traffic MO | |
| US-0059 IN WESB CO (784-828) | DERATE |
| Alleged: Speed Limit: Ascident 🗆 Radar C | al |
| Other Cond: | الله فيصيفها والمائمة فينيد للواقل بينا الله البيدة المراجعة المراجعة الله البيد |
| VIOLATIONS 1. NO VALID INSPECTION CERTIFICATE - EXPIRED (11/08 | #) EXPIRED |
| WARNINGS - NO PENALTY ASSESSED FOR THE FOLLOWIN | • • |
| DRIVE IN LEFT LANE WHEN NOT PASSING OR WI PROHIBITED | HERE |
| 2. SPEEDING OVER LIMIT (#) OVER 70 | |
| You are hereby notified to appear before: | |
| Judge: HON ŘÍCARDO RANGEL IN WESS CO. Court: JP Pt. & Place 22 Phone. (s | 3561 70 L6263 |
| 901 S MILMO LAREDO, TX 78043 | 75077510200 |
| On or before. Tue January 06, 2009 10:00:00AM | |
| Issued by 11557 - J TORRES JR. Region: 8 District: B Area 02 | |
| I hereby promise to appear at the time and place designal | ed in this notice: |
| SIGNATURE | |

IMPORTANT MESSAGE

Annually traffic law violations are recorded as a factor in about 85% of the rural traffic accidents in Texas. Approximately 60% of the traffic deaths in Texas occur on rural highways. The enforcement actions taken against you and any subsequent court actions are intended to secure compliance with the traffic laws by you and all other users of the highways. Failure to comply with your written promise to appear in court as made on this citation will constitute a separate offense with which you may be charged and result in warrants being issued for your arrest. The issuance of arrest warrants will make you subject to entry into the wanted persons files of this Department. Failure to appear in court or failure to satisfy a judgement ordering the payment of a fine and cost in the manner ordered by the court may result in the denial or renewal of

POTENTIAL SURCHARGE NOTICE:

"A conviction of an offense under a traffic law of this state or a political subdivision of

EPAHO042001209

PURCHASER'S RECEIPT PLEASE COMPLETE AND SIGN THIS MONCY ORDER PROMPTLY

293586425

PAID TO

01/00/2009 米米多1000。400米米

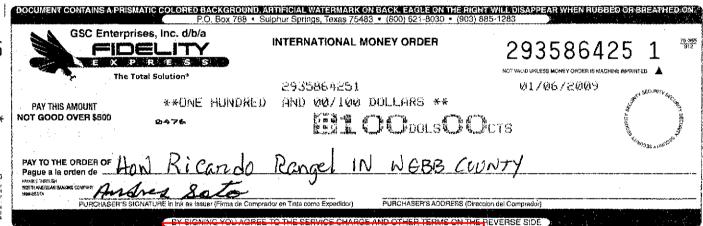
FIDELITY EXPRESS

P.O. Box 768 • Suiphur Springs, TX 75462-6768

For Money Order Inquiries call 800-621-8830

The customer agrees to \$11 mils money order form of the customer agrees to \$11 mils money order form or me at the opening provided. In the owner list manage order is lest on station, the customer list manage order is lest on station, the customer form the customer smould install needed of the customer smould install needed of the customer smould install needed of the money costs as it is the only covered of purchase of the money costs as it is the only covered on purchase of the money costs belong the serial number as lested above.

TX089 KDEKA





Illinois State Police Commercial Vehicle Sect 801 South 7th Street.

Post Office Box 19461, Suite 600 - S. Springfield, Illinois 62794-9461

Telephone (217)782-6267 Fax: (217)524-2391

DRIVER/VEHICLE EXAMINATION REPORT

71-2353-21-14

Report Number: IL3847000899 Inspection Date: 08/22/2008

Start Time: 03:10 PM End Time: 03:45 PM Insp. Level: II-Walk-Around, Bulk HM Insp.

CES ENVIRONMENTAL SERVICES INC

4904 GRIGGS ROAD HOUSTON, TX 77021

USDOT#: 00869392

Phone#: (713)676-1460

MC/MX#: 400234

State#:

2

Driver: MORALES, ROLANDO License#:

Date of Birth:

CoDriver:

License#:

State:

State: TX

Date of Birth:

MilePost: 152.35

Shipper: CES ENVIRONMENTAL SERVICES, INC

Bill of Lading: 70603

Cargo: LIQUIDS/GASES IN TANKS

Location: I-80 W/B AT CICERO AVENUE

Highway: INTERSTATE 80 W/B

County: COOK, IL

Origin: PORT ARTHUR, TX

Destination: WHEELING, IL

CVSA#

VEHICLE IDENTIFICATION

HEIL

Unit Type Make Year State 1 TT **PTRB** 2007 TX

License # TX

Company # 298 268

Vin#

GVWR 80.000

OOS#

BRAKE ADJUSTMENTS: No Brake Measurements Required For Level 2

VIOLATIONS

Section Code Type Unit OOS Citation # Verify Crash Violations Discovered

172.516(c)(6) F

HM WW

CLASS 3 FLAMMABLE PLACARD BEARING ID NUMBER #UN1193 LOCATED ON THE FRONT (NOSE) OF UNIT #2 (TRAILER) WAS TORN AND DAMAGED.

HazMat: 3 Flammable

Placard: Yes

Cargo Tank: 307

Special Checks: No Data for Special Checks.

1985

State Information:

HM Action 1)NAV 2)WW 3)INSP: 2; 5800.1 (Y/N): N; Photos (Y/N): N; Accident Report #: NA; Placards Rq'd (Y/N): Y; Placards Displayed 1: 3: ID# (UN/NA) 1: UN1193: 1-Shipper Name: CES ENVIRONMENTAL SERVICES: 1-Shipper Address: 2450 SOUTH GULFWAY DRIVE,; 1-ShipperCity: PORT ARTHUR,; 1-ST: TX; 1-ZIP: 77641; 1-BL#: 70603; 1-Consignee: SUNNYSIDE CORP., WHEELING, ILL; 1-PSN: METHYL ETHYL KETONE,; 1-HAZCLS: 3; 1-UN/NA#: UN1193; 1-PG: II; 1-PKG SPEC#: 307 CT; 1-QTY: ONE CT;

If your driver or vehicle was placed out of service, please verify the out of service violations noted on this report have been corrected. A copy of this form must be returned or faxed to the following address within 15 days.

Illinois State Police, Commercial Vehicle Section

801 South 7th Street, Post Office Box 19461, Suite 600 - S. Springfield, Illinois 62794-9464

Telephone: (217) 782-6267 Fax: (217) 524-2391

Signature Of Motor Carrier

Report Prepared By: T.P. RADULOVIC Badge #:





Equipment Work Order

| Unit: | TRL# | <u> みり4 </u> | Miles: | | | | | | | |
|-------------|---|---|------------------------|----------------|-------------------------------------|---------------|----------|--------------|--|--|
| Com | pany Owned | Yes No Bill To: | | | | | | | | |
| | rieman y proes de la Turante de la companya de la companya de la companya de la companya de la companya de la companya de la company | | | E 人名英格兰 (1987) | | | | | | |
| Job# | | | Description Of Repairs | | | | | | | |
| 1 | | SERVICE CALL NO TRAILER BRAKES | | | | | | | | |
| 2 | Contr | oller CAMP & Switch | - Missing | | | | | | | |
| 3 | | es out of Adjustme | | | | | | | | |
| 4 | TRACE | willing | | | | | | | | |
| 5 | | | | | | · | | | | |
| Job# | Work Code | Work Performe | ed | Tech | Hours | Labor \$ | Parts \$ | Total Cost | | |
| 2 | RPL | Replace Control CAble | & Switch | دعات | ,50 | 32.50 | 19.85 | 52.35 | | |
| Ä | RDR | Inspect & Adjust BRA | | ಲೇ | 175 | 48,75 | | 48:75 | | |
| 4 | RPR | TRACE + REPAIR WIRING to | | \$0 | 10 | 65 <u></u> ≝ | | 65 <u>00</u> | | |
| | | | <u>-</u> | | | | | | | |
| | | | Parts | | | 数 / 类。 | | <u> </u> | | |
| Job# | 1 | Part Description | Part Nu | mbor | Talking to the property of the con- | Qty | Cost | Ext Cost | | |
| 2 | BRAXE | Control Switch | 2010-P P | | | daty | 9,95 | 995 | | |
| 1 | | E APT CAble Switch | | | | <u> </u> | 9.90 | 9.90 | | |
| | DW W VC | HEL CAME 300 TO | | | | Ĺ | 7770 | | | |
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| | | | | | | 1 | <u> </u> | <u></u> | | |





Equipment Work Order

| Unit: | TRK# | 101 | Date: | 9-5-08 | | M | iles: | | | | _ |
|---------------|-------------|--|---|---|--|--|--------------|--|-----------|--|--|
| | pany Owned | | No | | SERVICE | | ···- | | | | |
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| Job# | | | 1 57 | <u></u> | Desc | ription Of Repair | <u> </u> | | | | |
| 1 | IRABL | E 82 00 | 5 RAKES | INDID | | | | * " | | | |
| 2 3 | | · | | | | | | | | | |
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| <u>4</u> 5 | | | | | <u> </u> | | | | | | |
| 3 | | | 5 34 22 1 3 1 | | | | | | | | |
| Job# | Work Code | | <u> </u> | Work Per | | | Tech | Hours | Labor \$ | Parts \$ | Total Cost |
| | RPR | Check | 4 Repair | MIRENS | 3 ST BRA | KE Controle | in So | 175 | 48,75 | | 48.75 |
| | <u> </u> | | | | | | | | <u> </u> | | |
| | <u> </u> | | | | ····· | ······································ | | | | | |
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| Job# | | <u> </u> | Part Description | · | | <u>Pa</u> | rt Number | | Qty | Cost | Ext Cost |
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| | Reviewed By | | | | | | Data Input E | Зу: | | | |

| TX036X90 | FN01 | PASADENA POLICE DEPARTMEN | CP#:0151 | LEVEL |
|---|--|---|--|---|
| ☑ APREST TKT | ☐ 9 - 15 PASS, FOR HIRE | | CF#.0151 | 1010 |
| Ø COM. VEH. ☐ ROCCEENT Ø COL | ☐ 16 PASS. FOR HIRE ☐ 16 PASS. NOT FOR HYAN SI ☐ SCHEDULT ☐ CHARTER | COMSTRUCT PROG: | ☑ NO SCALE | IDE ALCH DS . |
| DATE: | 09/05/2008 TIME: 8:10 | O AM COUNTY: HARRIS HW | 7: (2) SH-0225 IN HARRIS CO. | |
| LESSEE/HO: | | | USDOI | "#: 08693 92 |
| ACCAMITY/ST/GIP: | | | . ICC/M | IC#: 400234 |
| OWNER: CES ENV | IRONMENTAL SERVICES INC | <u> </u> | TXDOT | #: 005516524C |
| ADD/DITTY/ST/MIP: | 4904 GRIGGS ROAD HOUSTON TX | | PHONE | #: 713676146 0 |
|] | PH PATRICK HERNANDEZ | RACE/SEX: WM | DOS: (6) (4) HED C | |
| ADD/CITY/81/XIF: | (0) (4) | | ST: T | _ |
| VEH SEARCH: | _ · · · - · · | | PECTION CONTRABAND LOCATED | |
| TYPE OF SEARCH: | CONSENT LIBO INC. TO AS | REST INVENTORY TYPE OF CONTRAB. UNIT TYPE MAKE CO# :_ | and: drugs weapons Plate ST | CURRENCY DOTHER |
| | | 1 TR FORD 101 | (b) (4) TX | |
| V | | 2 ST AMEB 204 | TX | |
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| SIGNAT | | | | |
| I KERRBY PROMI PLACE DESIGNAT NOT A PLEA OF | SR TO APPEAR AT THE TIME AND ED IN THIS NOTICE. (THIS IS GUILTY) | x o oo | | |
| ₩ cos: secsiasp | ву | GROSS WEIGHT: | GROUP WEIGHT: | |
| _ | OTIFIED TO APPEAR | | LOAD DISP: | |
| JULGE: Pasaden | a Municipal COURT: | Municipal PCT./PLACE: 0/1 | PERMIT #: | ÷ |
| FRUME: (713) 47 | 5-9595 OM/BEFORE 21-Nov- | -2008 AF 10:00AM | RG WT #1 46000 GV | /WR #1 |
| ATPRESS: 1001-A E | SHAW AVE PASADENA TX 77506 | | RG WT #2 24000 GV | ŴR #2 |
| READ *** ALMOVED: | DEST. SEAL *; ENSTAU | ST ASYO THANGST ARVO | CAL-ST CVSA DECAL-ST | |
| | | | | |
| BEIFFING +; | | COMSIGGOR: | CONSIGNAE: | |
| namevereny: MA | CHINERY, LARGE OBJECT | ORIGIN: HOUSTON | TX DESTINATION: LAPORTE | TX |
| | | PLACARDS REQ? HYD HYD INOP INO | • | ED SPRED |
| | NA · | AX 1 AX 2 AX 3 AX | A AV S AV A AV 7 AV A | Limit |
| | | SPEC. TANK HYD HYD INOP INO | | 4.54. v |
| CLOKET VIOL. CITE : | Funit 00\$ 008 POST | VIOLATIO | ONS DISCOVERED | |
| 200 | No. Y/N DISP ACC | DRIVER:PLEASE COMPLY WITH DIRECTION | S ON BACK SIDE OF THIS FORM | |
| Yes 393.43 | 2 165 0 | NOT PROTECTED IN CASE OF BREAKA | WAI - NON FUNCTIONING | |
| 393.48(A) | 2 Yes U DEFECTIV | /E BRAKE - 20% OR MORE RULE | | |
| 393.48(A) | 2 DEFECTIV | /E BRAKE - AXLE 3 LEFT | | |
| 393.48(A) | 2 DEFECTIV | E BRAKE - AXLE 4 LEFT | | |
| 393.48(A) | 2 DEFECTIV | E BRAKE - AXLE 3 RIGHT | | |
| | | | | |
| | | HICLE/DRIVER OUT OF SERVICE NOT | | |
| er imm of mals for aggring to these defects have been | port. No person enail remove the o wenicles or operate such vehicles u repairs; and the vehicles have bee per operating authority has been ob | ntil the out of service - Out of Se n restored to safe operating - permit or | irsuant to authority contained in her 540 I hereby notify and the driver named on this report ervice. No motor carrier shall r require driver to drive or any motor vehicle until | OOS DISPOSITIONS A. Repaired at Scene / Obtained Oper. Auth. B. Towed/Sscored to Repair Service D. Other U. Unknown N. Oriver OOS |
| | | Y | | <u></u> |
| | | COFX | RECEIVED BY | Log Book Exemption |
| inspected by: | | STRICT/AREA TIME COMPLETED REPORT P | REPARED BY: SMITH, TIMOTHY | L |
| SMITH, TIMOTHY L CHARBES FILED BY: | 2W-0060 SMITH, TIMOTHY L 2W-00604 | 46 2 9 W 8:55AM REFERRA 46 29W BRAKES I | L ID NSPECTED BY: 2W-006046 | |
| | 2,, 22,000, | | | |

07/E-3a (12/03)

PASADENA POLICE
DEPARTMENT

CONTINUATION SHEET

INSPECTION #

TX086X9DFN01-0 MOTOR CARRIER DWTE

9/5/2008 8:10:00AM

OFERATOR HERNANDE

HERNANDEZ LAST MAME

JOSEPH

<u>PATRICK</u>

NOTE TO DRIVER: This report must be furnished to the motor carrier whose name appears on this report. NOTE TO MOTOR CARRIER: TRC Chapter 644 requires the Motor Carrier to execute the certification on the reverse side and return this report to Texas Department of Public Safety, Motor Carrier Safety Section, PO Box 4087, Austin, Texas 78773-0001 within fifteen (15) days.

| | | | VIOLATIONS | 5 | | | | |
|---------------------|---|-----------|----------------------------------|---------------------------------|---|-----|---|--|
| TICKET VEGL. ORTE # | | oos oos s | | VIOLATIONS DISCOVEREI |) | | • | |
| 393,48 (A) | 2 | | DEFECTIVE BRAKE - AXLE 4 RIGHT | e e e e e e e e e e e e e e e e | | n . | | |
| 393,43(D) | 1 | | NO SINGLE CONTROL TO OPERATE ALI | , Brakes - Missing | | | | |
| | | | | _ | | | | |

| | VEHICLE/DRIVER OUT OF SE | ERVICE NOTICE | |
|---|--|--|---|
| if Service" the vehicle/s with the column of this report. No personapplied to these vehicles or op- | defects followed by "TES" in the Out of Service on Shoil remove the out of service stickers estate such weblicles until the out of service that Yohicles have been restored to safe operating authority has been obtained. | TRO Chapter 644 I hereby notify and declare the driver hamed on this report Out of Service. No motor carrier shall | OOS DISPOSITIONS A. Repaired at Scame / Obtained Oper. Auch. B. Towed/Ascorted to Repair Service D. Other U. Behinoun N. Driver GOS |
| DRIVER CLEAR LOCAL | | | |
| | | X | Log Book Exemption |
| | | COPY RECEIVED BY | _ |
| INSSECTED BY: | ID/REGION/DISTRICT/AREA TIME COMPLET | ED REPORT PREPARES BY: SMITH, TIMOTHY | L. |
| SMITH, TIMOTHY L | 2W-006046 2 9 W 8:55AM | REFERRAJ. ID | |
| CHARGES FILES BY: SMITH, TIM | OTHY L 2W-006046 29W | BRAKĖS INSPECTED BY: 2w-006046 | |

JUDGE INFORMATION IS IN HEAVY BORDERED BOX ON DRIVER'S COPY.

PAYMENTS FOR FINES SHOULD BE SENT TO THE COURT LISTED ON THE DRIVER'S COPY.

DO NOT SEND PAYMENTS TO TX DPS/MCB.

CERTIFICATION OF REPAIRMAN

I CERTIFY THAT THE REQUIRED REPAIRS SHOWN IN THE "OUT OF SERVICE" COLUMN ON THE OTHER SIDE OF THIS CERTIFICATE HAVE BEEN SATISFACTORILY COMPLETED.

SIGNATURE OF REPAIRMAN:

NAME OF SHOP (GARAGE):

REPAIR WORK COMPLETED

Serve

Ces

08-08

DME: LAM

MOTOR CARRIER CERTIFICATION OF ACTION TAKEN

I CERTIFY THAT ALL VIOLATIONS NOTED UPON THIS REPORT HAVE BEEN CORRECTED AND ACTION HAS BEEN TAKEN TO ASSURE COMPLIANCE WITH THE MOTOR CARRIER SAFETY REGULATIONS INSOFAR AS THEY ARE APPLICABLE TO MOTOR CARRIERS AND DRIVERS.

SIGNATURE OF CARRIER OFFICIAL:

TITI E

DATE:

Bobber Though

HSE Nanage

9-5-08

ATTENTION DRIVER:

This report must be furnished to the motor carrier whose name appears on this report.

ATTENTION DRIVER:

TRC Chapter 644, Revised Statutes, requires the Motor Carrier to execute the above cartification

and return this report to: MOTOR CARRIER BUREAU

TEXAS DEPARTMENT OF PUBLIC SAFETY PO BOX 4087

AUSTIN TX 78773-0521

IMPORTANT MESSAGES

Any enforcement actions taken against you and any subsequent court actions are intended to secure compliance with the traffic laws and all other users of the highways. Failure to comply with your written promise to appear in court as made on this citation will constitute a separate offense with which you may be charged and result in warrants being issued for your arrest. Failure to appear in court or failure to satisfy a judgement ordering payment of a fine and cost in the manner ordered by the court may result in the denial of renewal of your driver's license.

"A second or subsequent conviction of failure to maintain financial responsibility will result in the suspension of your driver license and motor vehicle registration unless you file and maintain proof of financial responsibility with the Department of Public Safety for two (2) years from the date of conviction. The Department may waive the requirements to file proof of financial responsibility if you file satisfactory evidence with the Department showing that at the time this citation was issued the vehicle was covered by a liability insurance policy or that you were otherwise exempt from the requirements to provide evidence of financial responsibility.

You may be able to require that this charge be dismissed by successfully completing a driving safety course or a motorcycle operator training course. You will lose that right if, on or before your appearance date, you do not provide the court with notice of your request to take the course. This article does not apply to an offense committed by a person who holds a commercial driver's license.

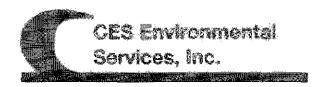
"A conviction of an offense under a traffic law of this state or a political subdivision of this state may result in the assessment on your driver's license of a surcharge under the Driver Responsibility Program."

A request for an out-of-service review, regarding operating authority, must be made in writing and forwarded to the manager of the Motor Carrier Bureau. If requested, a review will be scheduled and conducted by the manager of the Motor Carrier Bureau or the director's designee within 10 days of the issuance of the out-of-service order. A request for review should be addressed to the Texas Department of Public Safety, Motor Carrier Bureau, P.O. Box 4087, Austin, TX 78773-0521 or may be sent by facsimile transmission to (512) 424-5712 or via electronic mail at <u>MotorCarrierBureau@bxdps.state.bx.us.</u> The Department may conduct the review by telephone conference call.

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To obtain IFTA information contact the State of Texas Comptrollers Office at 1-800-252-1383 or visit their website at www.window.state.tx.us/taxinfo/fuels/fita.html.



SPILL REPORT

Date of Spill: December 4, 2008 Time ~ 9:00 a.m.

Cause of Spill: Punctured Chemical Tote

Is the spill reportable: No

Exact Location Where Incident Occurred: Chemical Storage Area

Describe Fully How Incident Occurred:

The spill occurred due to a chemical tote which was punctured by a forklift blade. The material spilled came from a tote of ferric chloride and was ~ 30 gallons. James Pharms, CES Tank Wash Manager was notified of the spill. James directed clean up and Absorbent Material was use to dry the product. Pressure Washers were used to clean the entire containment area. The absorbed product was shoveled into a 55 gallon drum for disposal at the Main Processing Facility. The diluted material from the pressure washing was picked up using Vacuum Trailer 204 and also transferred to the Main Processing Facility for disposal.

Recommendations to Prevent Reoccurrence: Disciplinary action taken against employee who operated the forklift.

Prepared by: Karl A. Guidry Title: CES Environmental HSE Manager Initials

Approved by: James Pharms Title: Tank Wash Manager Initials

| | TX070G0ALW0 | 14 | TXDPS COMME | RCIAL VEHICLI | É ENFORCEMEN | CD# • C | 11510 | LEVEL |
|-----|---|--|---|---|---|--|---|---|
| | ARREST TKT 9 COM. VEH. 16 ACCIDENT 16 ACCIDENT 16 CDL 50 DATE: 01/16 LESSEE/MC: ADD/CITY/ST/ZIP: OWNER: C E S ENVIROME ADD/CITY/ST/ZIP: 4904 OPERATOR: DAVID F VAN ADD/CITY/ST/ZIP: (b) (2 VEH SEARCH: YES TYPE OF SEARCH: CONS | - 15 PASS. FOR HIRE 5 PASS. FOR HIRE 5 PASS. NOT FOR HIRE CHEDULE | SP PROG: [40 AM COUNTY: MOBILE) HOUSTON STOP: WARN ARREST INVEN | INTERSTATE INTRASTATE JEFFERSON ITX 77013 RACE/S CITATION TORY TYPE O | EX: MM DOB: D.L.; INSPECTION OF CONTRABAND: O# PLAT | SR-0082 IN JE (D) (4) (CONTRABAND DRUGS WEA | FFERSON CO. USDOT#: ICC/MC#: TXDOT#: PHONE#: MED CARD: | ALCH DS SW TE M.P.#: 454 0869392 400234 005516524C 7136761460 02-24-2007 STATE: TX |
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| ŜĒ | column of this report. N applied to these vehicles defects have been repaire | rity contained in TRC Chap with defects followed by to person shall remove the or operate such vehicles d and the vehicles have be ating authority has been of TROOPER COMMENTS: | "TES" in the Out out of service st until the out of een restored to sa | ickers service | DRIVER Pursuant TRC Chapter 644 declare the driv Out of Service. I permit or requir operate any moto | I hereby notity a er named on this No motor carrier e driver to drive | report Obta shall B. T or Repa D. C | DISPOSITIONS Lepaired at Scene / Lined Oper. Auth. Owed/Escorted to Lir Service ther Inknown Driver OOS |
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| | ISPECTED BY: IKES, RONNIE GLENN | | | 6:56AM | REPORT PREPAREE REFERRAL ID | BI: FIKES, F | RONNIE GLENN | |
| | ARGES FILED BY: | | | | BRAKES INSPECTE | D BY: | | |
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JUDGE INFORMATION IS IN HEAVY BORDERED BOX ON DRIVER'S COPY.

PAYMENTS FOR FINES SHOULD BE SENT TO THE COURT LISTED ON THE DRIVER'S COPY.

DO NOT SEND PAYMENTS TO TX DPS/MCB.

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SIGNATURE OF REPAIRMAN:

NAME OF SHOP (GARAGE):

REPAIR WORK COMPLETED

_.

CES ENVIRONMITAL

DATE: 17-07 2 Pm

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TITLE:

DATE:

Follow Klyn

HSE Manager

1-17-07

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PO BOX 4087

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Equipment and Facility Work Order

| Date - 17-07 | | | | |
|--|--|--|--|--|
| Equipment Number or Description | CES Customer and Job (for customer damage only) | | | |
| TRX # 2949 | | | | |
| Equipment Type or Area | | | | |
| | · Van de la company de la comp | | | |
| Description of Job | | | | |
| | | | | |
| Description of Work Preformed | Cost of Parts Labor Hours Worked | | | |
| ME POTIA LIGARS | | | | |
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| Shop Suppl | is 1000 | | | |
| Total Cost for Parts \$ <u>35 で</u> Total Labor (hours x \$55.00) \$ <u>82,50</u> | | | | |
| Total Cost to Complete Work \$//7.50 | | | | |

| | LOUISIANA STA MOTOR CARRIE P.O.BOX 6 | R SAFETY | Haz. Mat. P. Yes No | Level 7 | p Inspection Report No. 721922 Oata No. |
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| Oate Tim | ne Location | Scales Roadside Fixe | d Site Mile Post # | Parish | State Number |
| Carrier Name | | Driver's Name (L., F., Mi.) | | Shipper's Name (Haz. M | tal./Waste Only) |
| Carrier Address | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | Drivel's Address | | Shipper's Address | ~ · ('^; , (|
| Carner City | State Zip Code | Driver's City | otate zip Code | Shipper's City | State Zip Code |
| ihlerstate Carder | | Driver's tic. No. | 77 17 State | Class Date of Birth | h Haz, Mat, Incident # |
| 70 J. 890506 39461676 | VEHICLE/UNIT TYPE. | Unit Year Make | Type GVWR | Company No. Lice | nse No. State CVSA DECAL# |
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| | | As provided in Chapter 12 of L QUALIFIED (out of service) | | | |
| | | a rinver who is DISQUALIFIED | (out of service) to | drive a commercial motor | vehicle. |
| as or licate | vice repairs verified. d in OK column Sig i Data No. of Inspection Officer | Patture | Date 5 | ApencyApency Time eted: | |
| E inderstånd and a of ensemble inmfor ensemble healing in | knowledge that the findmark Depart leman penalties for the vicks onner to accordance with the Administrative P | nent of Public Sabity and Corrections scribed above. Further, the carrier, strategies Adt, for the proposed division | may notify the carries. | | per unity to request a for uno |
| Home forminal (Cit | y & State) | Term Manager/Owner | Official Origin | Destination | 77.0 |
| Signature of Orive | r/Carrier Official | Terminal Telephone N | lumber Driver | Telephone Number | ,, |
| 0PSSP 1000 (P 5) 41 | | | <u> </u> | | |

ATTENTION DRIVER, CARRIER, AND/OR SHIPPER

721922

PLACE POSTAGE HERE

The driver and/or carrier has been inspected by a Louisiana State Trooper for compliance with the FMCSR. In accordance with PMCSR the driver of any motor vehicle receiving an inspection report shall deliver it to the motor carrier upon his return to the next terminal or facility. If the driver is not scheduled to arrive at a terminal or facility within 24 hours, the driver shall immediately mail the report to the motor carrier. If your vehicle was transporting hazardous materials at the time of the inspection the driver, carrier, and/or shipper may be inspected for compliance with the CFR 49 Transportation of Hazardous Materials.

NOTE: ANY VIOLATIONS OF THE FMCSR OR THE CFR 49 TRANSPORTATION OF HAZARDOUS MATERIALS REGULATIONS MAY SUBJECT THE DRIVER, CARRIER, AND/OR SHIPPER TO MONETARY CIVIL PENALTIES. THE DRIVER, CARRIER, AND/OR SHIPPER WILL BE NOTIFIED IN APPROXIMATELY 4-6 WEEKS OF ANY PENALTIES ASSESSED AGAINST THEM. FMCSR'S REQUIRE THE REPAIR OF ANY VEHICLE DEFECT LISTED ON THIS REPORT. HOWEVER, REPAIRING THE DEFECT WILL NOT PRECLUDE THE POSSIBILITY OF A MONETARY PENALTY BEING ASSESSED.

PRET FOLD BERT NOTE TO CARRIER: Violations other than out-of-service conditions noted on this report must be corrected or repaired prior to the redispatch of the vehicle. In accordance with FMCSR 369.9(d)2 the motor carrier SHALL certify that all violations noted have been corrected by the below certification statement and returning it to the office indicated below within 15 days following the date of inspection. A copy of this inspection report must be retained at the motor carrier's principal place of business or where the vehicle is housed for 12 months from the date of inspection. Failure to properly certify noted repairs can result in additional penalties. CERTIFICATION OF ACTION TAKEN THE UNDERSIGNED CERTIFIES THAT ALL VIOLATIONS NOTED ON THIS REPORT HAVE BEEN CORRECTED AND ACTION HAS BEEN TAKEN TO ASSURE COMPLIANCE WITH THE LOUISIANA DEPARTMENT OF PUBLIC SAFETY MOTOR CARRIER SAFETY AND HAZARDOUS MATERIAL REGULATIONS INSOFAR AS THEY ARE APPLICABLE TO MOTOR CARRIERS AND DRIVERS HSE Manager 1-15-07 Signature of carrier official Date signed SECOND FOUR DIRECT

> LOUISIANA STATE POLICE MOTOR CARRIER SAFETY P.O.BOX 66601 BATON ROUGE, LA 70896-6601

| TX07030ANZ05 | TXDPS COMMERCIAL VEHICLE ENFORCEMENT CP#: 0151818 |
|--|---|
| ☐ ARREST TKT ☐ 9 - 15 PASS. FOR HIRE | CP#: 0151818 2 |
| OM. VEH. 16 PASS. FOR HIRE ACCIDENT 16 PASS. NOT FOR HIRE | CONSTRUCTION ZONE FIXED ROADSIDE ALCH D |
| CDL SCHEDULE CHARTER | SP PROG: W INTERSTATE YES NO SCALE ACCH D INTRASTATE OCCUPIED HOUSE 2A699 SW T |
| DATE: 01/03/2007 TIME: | 9:50 AM COUNTY: NACOGDOCHES HWY: (2) US-0059 IN NACOGDOCHES CO. M.P.#: 376 |
| LESSEE/MC: C E S ENVIROMENTAL SERVICES | USDOT#: 0869392 |
| ADD/CITY/ST/ZIP: 4904 GRIGGS RD (3901 TR | AILMOBILE) HOUSTON TX 77013 ICC/MC#: 400234 |
| OWNER: STEVEN K STRICKER | TXDOT#: 005516524C |
| ADD/CITY/ST/2IP: (b) (4) | PHONE#: 7136761460 |
| OPERATOR: ALBERTO HERNANDEZ | RACE/SEX: HM DOB: (b) (4) MED CARD: 8-23-08 |
| ADD/CITY/ST/ZIP: (b) (4) | D.L.#: (b) (4) STATE: TX |
| VEH SEARCH: ☐ YES ☑ NO REASON FO | R STOP: WARN CITATION INSPECTION CONTRABAND LOCATED: YES NO |
| TYPE OF SEARCH: CONSENT PC INC. I | O ARREST INVENTORY TYPE OF CONTRABAND: DRUGS WEAPONS CURRENCY OTHER |
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| V /2.2/ | 2 ST POLA 225 TANDER TX |
| A CALLAGORICA STORES | |
| l / / | |
| I HEREBY PROMISE TO APPEAR AT THE TIME AN PLACE DESIGNATED IN THIS NOTICE. (THIS IS | D ; |
| NOT A PLEA OF GUILTY) | X-00-00 |
| COPY RECEIVED BY | GROSS WEIGHT: GROUP WEIGHT: |
| YOU ARE HEREBY NOTIFIED TO APPEAR | LOAD DISP: |
| JUDGE: COURT: | PCT./PLACE: PERMIT #: |
| PHONE: ON/BEFORE | AT RG WT #1 80000 GVWR #1 |
| ADDRESS: | RG WT #2 0 GVWR #2 |
| SEAL #'S REMOVED: DEPT. SEAL #; INS | TALLED CVSA DECAL-TT CVSA DECAL-ST CVSA DECAL-ST |
| | |
| SHIPPING #: 33169 | CONSIGNOR: CES ENVIRONMENTAL CONSIGNEE: INLAND PRODUCTS |
| COMMODITY: FLAMMABLE LIQUIDS | ORIGIN: HOUSTON TX DESTINATION: KILGORE T |
| HM CATEGORY CODE RQ? | W? PLACARDS REQ? ALLEGED SPEED |
| BULK 3 | SPEED LIMIT |
| : | SPEC. TANK AX 1 AX 2 AX 3 AX 4 AX 5 AX 6 AX 7 AX 8 RADAR CAL. |
| | 307 L |
| TICKET VIOL. CITE # Unit OOS OOS POST No. Y/N DISP ACC | VIOLATIONS DISCOVERED DRIVER: PLEASE COMPLY WITH DIRECTIONS ON BACK SIDE OF THIS FORM |
| | TIVE SIDE MARKER LAMP - RIGHT FRONT |
| 393.20 1 DEFE | TIVE CLEARANCE LAMP - RIGHT |
| | |
| 393.11 1 DEFE | CTIVE ID LAMP (FRONT/REAR) - RIGHT |
| | |
| | |
| | |
| | VEHICLE/DRIVER OUT OF SERVICE NOTICE |
| — of Service" the vehicle/s with defects followed | hapter 644 I hereby declare "Out DRIVER Pursuant to authority contained in OOS DISPOSITIONS by "YES" in the Out of Service TRC Chapter 644 I hereby notify and A. Repaired at Scene |
| column of this report. No person shall remove t applied to these vehicles or operate such vehicl | es until the out of service Out of Service. No motor carrier shall B. Towed/Escorted to |
| defects have been repaired and the vehicles have condition, or proper operating authority has bee | |
| SEE CONTINUATION SHEET TROOPER COMMENTS: | N. Driver OOS |
| | V |
| | Log Book Exemptio |
| INSPECTED BY: ID/REGION | COPY RECEIVED BY /DISTRICT/AREA TIME COMPLETED REPORT PREPARED BY: DUNKIN, DENMAN BOWEN |
| (| 48 2 A 06 10:15AM REFERRAL ID |
| CHARGES FILED BY: | BRAKES INSPECTED BY: |

JUDGE INFORMATION IS IN HEAVY BORDERED BOX ON DRIVER'S COPY.

PAYMENTS FOR FINES SHOULD BE SENT TO THE COURT LISTED ON THE DRIVER'S COPY. DO NOT SEND PAYMENTS TO TX DPS/MCB.

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SIGNATURE OF REPAIRMAN:

NAME OF SHOP (GARAGE):

REPAIR WORK COMPLETED

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TITLE:

DATE:

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HSE Manager

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To obtain a USDOT Number contact the Federal Motor Carrier Safety Administration at 1-800-832-5660 or visit their website at www.fmcsa.dot.gov/factsfigs/formspubs.htm.

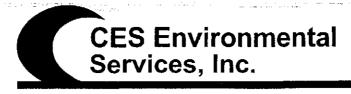
To obtain IFTA information contact the State of Texas Comptrollers Office at 1-800-252-1383 or visit their website at www.window.state.tx.us/taxinfo/fuels/ifta.html.



Equipment and Facility Work Order

| er and Job (for customer amage only) Parts Labor Hours Worked |
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| Parts Labor Hours Worke |
| Parts Labor Hours Worked |
| |
| 1.0 |
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White - Equipment and Maintenance Files Goldenrod - Customer Service (If Applicable)



Equipment and Facility Work Order

| Date 1-3-07 | | | |
|---------------------------------|---|--------------------|--|
| Equipment Number or Description | CES Customer and Job (for customer damage only) | | |
| TRL# 725 | | | |
| Equipment Type or Area | | | |
| Description of Job | | | |
| | | | |
| Description of Work Preformed | Cost of Parts | Labor Hours Worked | |
| REALLY RIFE MINERIES LIGHT | (1) Bulb | 1.0 | |
| | | | |
| | | | |
| | | | |
| | | | |
| Show Supplies | 10 00 | | |
| Total Cost for Parts \$ | | | |
| otal Cost to Complete Work \$ | | | |

White - Equipment and Maintenance Files Goldenrod - Customer Service (If Applicable)

| TX070P0BAI04 | TXDPS COMMERCIAL VEHICLE ENFORCEMENT CD# . 01 E 1 0 1 0 |
|---|--|
| ☐ ARREST TKT ☐ 9 - 15 PASS. FOR HIRE | CP#: 0151818 |
| COM. VEH. 16 PASS. FOR HIRE | CONSTRUCTION ZONE FIXED ROADSIDE |
| ☐ ACCIDENT ☐ 16 PASS. NOT FOR HIRE ☐ CHARTER | SP PROG: INTERSTATE YES NO SCALE HOUSE 2A301 SW TE |
| DATE: 01/25/2007 TIME: 1 | D:38 AM COUNTY: WALKER HWY: (1) IH-0045 IN WALKER CO. (101- M.P. #: 101 |
| LESSEE/MC: ADD/CITY/ST/2IP: | USDOT#: 0869392 |
| OWNER: C E S ENVIROMENTAL SERVICES | TXDOT#: 005516524C |
| | ILMOBILE) HOUSTON TX 77013 PHONE#: 7136761460 |
| OPERATOR: DALE RUSSELL HABADA | RACE/SEX: WM DOB: (b) (4) MED CARD: 12/5/07 |
| ADD/CITY/ST/ZIP: (b) (4) | D.L.#: (b) (4) STATE: TX |
| VEH SEARCH: YES NO REASON FOR | |
| TYPE OF SEARCH: CONSENT PC INC. TO | |
| | UNIT TYPE MAKE CO# PLATE ST |
| | 1 TT PTRB 287 (6) (4) TX |
| X Cale Haloola | 2 ST OTHR 1264 ME ME |
| / | |
| SIGNATURE: | |
| I HEREBY PROMISE TO APPEAR AT THE TIME AN PLACE DESIGNATED IN THIS NOTICE. (THIS IS | |
| NOT A PLEA OF GUILTY) | X(0) = -00(0) = -00(0) |
| ☑ COPY RECEIVED BY | GROSS WEIGHT: 0 GROUP WEIGHT: 0 |
| YOU ARE HEREBY NOTIFIED TO APPEAR | LOAD DISP: |
| JUDGE: COURT: | PCT_/PLACE: PERMIT #: |
| PHONE: ON/BEFORE | AT RG WT #1 80000 GVWR #1 |
| ADDRESS: | RG WT #2 0 GVWR #2 |
| SEAL #'S REMOVED: DEPT. SEAL #; INS | PALLED CVSA DECAL-TT CVSA DECAL-ST CVSA DECAL-ST |
| | |
| SHIPPING #: 002161561 | CONSIGNOR: CES ENVIRNMENTAL CONSIGNEE: PSC CRS |
| COMMODITY: CHEMICALS | ORIGIN: LAQ PORTE TX DESTINATION: AVALON TX |
| HM CATEGORY CODE RQ? H | 7? PLACAROS REQ? ALLEGED SPEED |
| BULK 3 🗆 | □ ☑ R SPÉED LIMÏT |
| _ | SPEC. TANK AX 1 AX 2 AX 3 AX 4 AX 5 AX 6 AX 7 AX 8 RADAR CAL. |
| · | 307 L |
| TICKET VIOL, CITE # Unit OOS OOS POST No. Y/N DISP ACC | VIOLATIONS DISCOVERED DRIVER: PLEASE COMPLY WITH DIRECTIONS ON BACK SIDE OF THIS FORM |
| | TIVE TURN SIGNAL LAMP (#) - LT TURN INOP |
| 393.25(f) 1 DEFEC | TIVE STOP LAMP (#) - LT STOP LAMP INOP |
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| | VEHICLE/DRIVER OUT OF SERVICE NOTICE |
| of Service the Admicte's with defects fortowed p | |
| column of this report. No person shall remove th applied to these vehicles or operate such vehicle | s until the out of service Out of Service. No motor carrier shall B. Towed/Escorted to |
| defects have been repaired and the vehicles have condition, or proper operating authority has been | been restored to safe operating permit or require driver to drive or Repair Service obtained. D. Other U. Unknown D. Other D. Other D. Other D. Other D. Unknown D. Unknow |
| SEE CONTINUATION SHEET TROOPER COMMENTS: | N. Driver OOS |
| DRIVER PHONE / (4) PEXOOT REQUIRED / YES / 0055165246 | VO. Ho |
| rxiot require <u>b/yes/1005165240</u> Waste flammable liquids/nos.{dimethyl sulfoxid | E) 3, UN1993 PGIII X & Log Book Exemption |
| INCODE/IND DV. | COPY RECEIVED BY DISTRICT/AREA TIME COMPLETED REPORT PREPARED BY: BOYD, PERRY |
| | 11:07AM REFERRAL ID |
| CHARGES FILED BY: | BRAKES INSPECTED BY: |

JUDGE INFORMATION IS IN HEAVY BORDERED BOX ON DRIVER'S COPY.

PAYMENTS FOR FINES SHOULD BE SENT TO THE COURT LISTED ON THE DRIVER'S COPY.

DO NOT SEND PAYMENTS TO TX DPS/MCB.

CERTIFICATION OF REPAIRMAN

I CERTIFY THAT THE REQUIRED REPAIRS SHOWN IN THE "OUT OF SERVICE" COLUMN ON THE OTHER SIDE OF THIS CERTIFICATE HAVE BEEN SATISFACTORILY COMPLETED.

SIGNATURE OF REPAIRMAN:

NAME OF SHOP (GARAGE):

REPAIR WORK COMPLETED

DATE: 1-25-0

TIME:

MOTOR CARRIER CERTIFICATION OF ACTION TAKEN

I CERTIFY THAT ALL VIOLATIONS NOTED UPON THIS REPORT HAVE BEEN CORRECTED AND ACTION HAS BEEN TAKEN TO ASSURE COMPLIANCE WITH THE MOTOR CARRIER SAFETY REGULATIONS INSOFAR AS THEY ARE APPLICABLE TO MOTOR CARRIERS AND DRIVERS.

SIGNATURE OF CARRIER OFFICIAL:

TITLE: ,
HSE Manager

DATE:

1-29-07

ATTENTION DRIVER: This repo

This report must be furnished to the motor carrier whose name appears on this report.

ATTENTION DRIVER:

TRC Chapter 644, Revised Statutes, requires the Motor Carrier to execute the above certification

and return this report to:

MOTOR CARRIER BUREAU TEXAS DEPARTMENT OF PUBLIC SAFETY

PO BOX 4087

AUSTIN TX 78773-0521

IMPORTANT MESSAGES

Any enforcement actions taken against you and any subsequent court actions are intended to secure compliance with the traffic laws and all other users of the highways. Failure to comply with your written promise to appear in court as made on this citation will constitute a separate offense with which you may be charged and result in warrants being issued for your arrest. Failure to appear in court or failure to satisfy a judgement ordering payment of a fine and cost in the manner ordered by the court may result in the denial of renewal of your driver's license.

"A second or subsequent conviction of failure to maintain financial responsibility will result in the suspension of your driver license and motor vehicle registration unless you file and maintain proof of financial responsibility with the Department of Public Safety for two (2) years from the date of conviction. The Department may waive the requirements to file proof of financial responsibility if you file satisfactory evidence with the Department showing that at the time this citation was issued the vehicle was covered by a liability insurance policy or that you were otherwise exempt from the requirements to provide evidence of financial responsibility.

You may be able to require that this charge be dismissed by successfully completing a driving safety course or a motorcycle operator training course. You will lose that right if, on or before your appearance date, you do not provide the court with notice of your request to take the course. This article does not apply to an offense committed by a person who holds a commercial driver's license.

"A conviction of an offense under a traffic law of this state or a political subdivision of this state may result in the assessment on your driver's license of a surcharge under the Driver Responsibility Program."

A request for an out-of-service review, regarding operating authority, must be made in writing and forwarded to the manager of the Motor Carrier Bureau. If requested, a review will be scheduled and conducted by the manager of the Motor Carrier Bureau or the director's designee within 10 days of the issuance of the out-of-service order. A request for review should be addressed to the Texas Department of Public Safety, Motor Carrier Bureau, P.O. Box 4087, Austin, TX 78773-0521 or may be sent by facsimile transmission to (512) 424-5712 or via electronic mail at MotorCarrierBureau@txdps.state.tx.us. The Department may conduct the review by telephone conference call.

To obtain a TxDOT Motor Carrier Insurance Certificate or Single State Registration - contact the Texas Department of Transportation at 1-800-299-1700 or visit their website at www.dot.state.tx.us.

To obtain a USDOT Number contact the Federal Motor Carrier Safety Administration at 1-800-832-5660 or visit their website at www.fmcsa.dot.gov/factsfigs/formspubs.htm.

To obtain IFTA information contact the State of Texas Comptrollers Office at 1-800-252-1383 or visit their website at www.window.state.tx.us/taxinfo/fuels/ifta.html.



Equipment and Facility Work Order

| Date 1-25-07 Equipment Number or Description | | CES Customer and | |
|--|---------------------------------------|------------------|---------------------------------------|
| 7FK4 787 | · <u></u> | damage | only) |
| Equipment Type or Area | | | |
| | | | |
| Description of Job パラット とうして | | | |
| | | | |
| Description of Work Preformed | | Cost of Parts | Labor Hours Worke |
| Preside bights + CHOCK A | 1 hall | 1 / fighs 734 | 20 |
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| otal Cost for Parts \$ | | | |

White - Equipment and Maintenance Files Goldenrod - Customer Service (If Applicable)

| TX07110ABX05 ✓ ARREST TKT 9 - 15 PASS. FOR HIRE | TXDPS COMMERCIAL VEHICLE ENFORCE | EMENT ODE OTETOTO |
|--|---|--|
| | INDI G GOMMENGIAE VERTICEE EM GROE | EMEN CP#: 0151818 |
| ☑ COM. VEH. ☐ 16 PASS. FOR HIRE | CONSTRUCT | ION ZONE FIXED TROADSIDE |
| ☐ ACCIDENT ☐ 16 PASS. NOT FOR HIRE ☐ CDL ☐ SCHEDULE ☐ CHARTER | SP PROG: INTERSTATE YES | NO SCALE ALCH DS |
| - CHARLE | ☐ INTRASTATE ☐ OCCUP | |
| DATE: 02/06/2007 TIME: | B:22PM COUNTY: VICTORIA RWY | : (2) US-0059 IN VICTORIA CO. (6: M.P.#: 622 |
| LESSEE/MC: C E S ENVIROMENTAL SERVICES | TIMODITE UNICHON MY 37013 | USDOT#: 0869392 |
| ADD/CITY/ST/ZIP: 4904 GRIGGS RD (3901 TRA | ILMOSILLY ROUSION TX 77013 | ICC/MC#: 400234 |
| OWNER: STEVEN K STRICKER | | TXDOT#: 005516524C |
| ADD/CITI/SI/EIF. | DIOD (ODV. | PHONE#: 7136761460 |
| OPERATOR: SEBASTIEN MCCRIMMONS | RACE/SEX: BM | DOB: (4) MED CARD: |
| ADD/CITY/ST/ZIP: (b) (4) | id | |
| VEH SEARCH: ☐ YES ☑ NO REASON FOR | | ECTION CONTRABAND LOCATED: YES NO |
| TYPE OF SEARCH: CONSENT PC INC. TO | | Control of the Contro |
| | | PLATE ST. 0) (4) TX |
| X Salvata MECS | 1 TT PTRB 286 C | ME NO SECURE OF THE PROPERTY OF A PARTY OF THE PROPERTY OF A PARTY OF THE PARTY OF |
| X Laborasin | Nym tanàna ao Fisiana | |
| SIGNATURE: | | |
| I I HEREBY PROMISE TO APPEAR AT THE TIME AN | n. | |
| PLACE DESIGNATED IN THIS NOTICE. (THIS IS | | |
| NOT A PLEA OF GUILTY) | X-0000 | |
| ☑ COPY RECEIVED BY | GROSS WEIGHT: | GROUP WEIGHT: |
| YOU ARE HEREBY NOTIFIED TO APPEAR | | LOAD DISP: |
| JUDGE: HENRY A WELFEL COURT: JP | PCT./PLACE: 4/0 | PERMIT #: |
| PHONE: (361) 573-5073 ON/BEFORE 23 | -Feb-2007 AT 10:00AM | RG WT #1 80,000 GVWR #1 |
| ADDRESS: 104 TEARWOOD STE #3 VICTORIA TX 779 | 01 | RG WT #2 0 GVWR #2 |
| SEAL #'S REMOVED: DEPT. SEAL #; INS | TALLED CVSA DECAL-TT CVSA DEC | CAL-ST CVSA DECAL-ST |
| · · | | · · · · · · · · · · · · · · · · · · · |
| SHIPPING #: | CONSIGNOR: CES ENVIRONMENTAL SERVICES | CONSIGNEE: CES ENVIRONMENTAL SERVICES |
| COMMODITY: EMPTY | ORIGIN: BEEVILLE | TX DESTINATION: HOUSTON T |
| HM CATEGORY CODE RO? H | W? PLACAROS REQ? | ALLEGED SPEED |
| NA | | SPEED LIMIT |
| | SPEC. TANK AX 1 AX 2 AX 3 AX 4 | AX 5 AX 6 AX 7 AX 8 RADAR CAL. |
| | L | |
| TICKET VIOL. CITE # Unit OOS Y/ OOS POST No. N DISP ACC | VIOLATION DRIVER: PLEASE COMPLY WITH DIRECTIONS | NS DISCOVERED |
| | RED CMV INSPECTION CERTIFICATE / AN | |
| Ves 896.17(c) 7 EXPI | | |
| res | TIVE TIDN STONAL LAND (A) - DICUT DEAD | |
| 393.19 1 DEFEC | TIVE TURN SIGNAL LAMP (#) - RIGHT REAR | |
| 393.19 1 DEFEC | TIVE TURN SIGNAL LAMP (#) - RIGHT REAR | |
| 393.19 1 DEFEC | | TE |
| 393.19 1 DEFEC | TIVE STOP LAMP (#) - RIGHT | TE. |
| 393.19 1 DEFEC | TIVE STOP LAMP (#) - RIGHT | TE |
| 393.19 1 DEFEC | TIVE STOP LAMP (#) - RIGHT | |
| 393.19 1 DEFECTION OF THE CONTROL OF | TIVE STOP LAMP (#) - RIGHT TIVE SIDE MARKER LAMP - LEFT INTERMEDIAT VEHICLE/DRIVER OUT OF SERVICE NOTIC apter 644 I hereby declare "out IT DRIVER Put | E |
| 393.19 1 DEFECTION 393.11 2 DEFECTION VEHICLE Pursuant to authority contained in TRC Ch of Service" the vehicle/s with defects followed b column of this report. No person shall remove the | TIVE STOP LAMP (#) - RIGHT TIVE SIDE MARKER LAMP - LEFT INTERMEDIA: VEHICLE/DRIVER OUT OF SERVICE NOTIC apter 644 I hereby declare "Out DRIVER Pur y "YES" in the Out of Service out of service stickers declare the | Suant to authority contained in 1008 DISPOSITIONS a 644 I hereby notify and A. Repaired at Scene of driver named on this report 100 tained Oper. Auth. |
| 393.19 1 DEFECT 393.11 2 DEFECT VEHICLE Pursuant to authority contained in TRC Ch of Service" the vehicle/s with defects followed be column of this report. No person shall remove the applied to these vehicles or operate such vehicle defects have been repaired and the vehicles have condition, or proper operating authority has been | TIVE STOP LAMP (#) - RIGHT TIVE SIDE MARKER LAMP - LEFT INTERMEDIATE VEHICLE/DRIVER OUT OF SERVICE NOTIC apter 644 I hereby declare "Out y"YES" in the Out of Service e out of service stickers suit the out of service been restored to safe operating permit or | E Suant to authority contained in DOS DISPOSYTIONS From the first of the firs |
| 393.19 1 DEFECT 393.15 1 DEFECT 393.11 2 DEFECT Of Service" the vehicle/s with defects followed be column of this report. No person shall remove the applied to these vehicles or operate such vehicle defects have been repaired and the vehicles have condition, or proper operating authority has been EEE CONTINUATION SHEET TROOPER COMMENTS: | VEHICLE/DRIVER OUT OF SERVICE NOTICe apter 644 T hereby declare "Out y "YES" in the Out of Service e out of service stickers suntil the out of service been restored to safe operating obtained. | Buant to authority contained in COS DISPOSITIONS A. Repaired at Scene Obtained Oper. Auth. S. Towed/Escorted to require driver to drive or y motor vehicle until D. Other U. Unknown N. Driver COS |
| 393.19 1 DEFECT 393.15 1 DEFECT 393.11 2 DEFECT Of Service" the vehicle/s with defects followed be column of this report. No person shall remove the applied to these vehicles or operate such vehicle defects have been repaired and the vehicles have condition, or proper operating authority has been EEE CONTINUATION SHEET TROOPER COMMENTS: | VEHICLE/DRIVER OUT OF SERVICE NOTICe apter 644 T hereby declare "Out y "YES" in the Out of Service e out of service stickers suntil the out of service been restored to safe operating obtained. | Buant to authority contained in COS DISPOSITIONS A. Repaired at Scene Obtained Oper. Auth. S. Towed/Escorted to require driver to drive or y motor vehicle until D. Other U. Unknown N. Driver COS |
| 393.19 1 DEFECT 393.15 1 DEFECT 393.11 2 DEFECT Of Service" the vehicle/s with defects followed be column of this report. No person shall remove the applied to these vehicles or operate such vehicle defects have been repaired and the vehicles have condition, or proper operating authority has been EEE CONTINUATION SHEET TROOPER COMMENTS: | VEHICLE/DRIVER OUT OF SERVICE NOTICe apter 644 T hereby declare "Out y "YES" in the Out of Service e out of service stickers suntil the out of service been restored to safe operating obtained. | Buant to authority contained in COS DISPOSITIONS A. Repaired at Scene Obtained Oper. Auth. S. Towed/Escorted to require driver to drive or y motor vehicle until D. Other U. Unknown N. Driver COS |
| 393.19 1 DEFECT 393.15 1 DEFECT 393.11 2 DEFECT Of Service" the vehicle/s with defects followed be column of this report. No person shall remove the applied to these vehicles or operate such vehicle defects have been repaired and the vehicles have condition, or proper operating authority has been EEE CONTINUATION SHEET TROOPER COMMENTS: | VEHICLE/DRIVER OUT OF SERVICE NOTIC apter 644 I hereby declare "out grace out of service e out of service suntil the out of service been restored to safe operating obtained. CPIRED JULY 2006 | Buant to authority contained in COS DISPOSITIONS A. Repaired at Scene Obtained Oper. Auth. S. Towed/Escorted to require driver to drive or y motor vehicle until D. Other U. Unknown N. Driver COS |
| 393.19 1 DEFECTION ON TRAILER EX | VEHICLE/DRIVER OUT OF SERVICE NOTIC apter 644 I hereby declare "out grace out of service e out of service suntil the out of service been restored to safe operating obtained. CPIRED JULY 2006 | suant to authority contained in cost bigspositions are 644 I hereby notify and edriver named on this report vice. No motor carrier shall require driver to drive or y motor vehicle until D. Other U. Unknown N. Driver OOS CCEIVED BY Suant to authority contained in cost bigspositions A. Repaired at Scene Obtained Oper. Auth. B. Towed/Escorted to Repair Service D. Other U. Unknown N. Driver OOS |

ANY ENTRIES IN THE VIOLATIONS SECTION OF DRIVER'S COPY INDICATES CHARGES FILED AGAINST THE DRIVER, THIS WILL REQUIRE CONTACTING THE JUDGE FOR APPROPRIATE DISPOSITION. (JUDGE INFORMA-TION IN HEAVY BORDERED BOX ON DRIVER'S COPY.)

ATTENTION DRIVER: This report must be furnished to the motor carrier whose name appears on this report.

ATTENTION DRIVER: TRC Chapter 644, Revised Statutes, requires the Motor Carrier to execute the below certification

MOTOR CARRIER SAFETY SECTION and return this report to:

TEXAS DEPARTMENT OF PUBLIC SAFETY

PO BOX 4087

AUSTIN TX 78773-0521

CERTIFICATE OF REPAIRMAN I CERTIFY THAT THE REQUIRED REPAIRS SHOWN IN THE "OUT OF SERVICE" COLUMN ON THE OTHER SIDE OF THIS CERTIFICATE HAVE BEEN SATISFACTORILY COMPLETED. SIGNATURE OF REPAIRMAN: NAME OF SHOP (GARAGE): REPAIR WORK COMPLETED DATE: TIME: ユーロー

MOTOR CARRIER CERTIFICATION OF ACTION TAKEN

I CERTIFY THAT ALL VIOLATIONS NOTED UPON THIS REPORT HAVE BEEN CORRECTED AND ACTION HAS BEEN TAKEN TO ASSURE COMPLIANCE WITH THE MOTOR CARRIER SAFETY REGULATIONS INSOFAR AS THEY ARE APPLICABLE TO MOTOR CARRIERS AND DRIVERS.

TITLE:

SIGNATURE OF CARRIER OFFICIAL:

HSE Manager

2-7-07

THIS FORM MUST BE RETURNED TO MOTOR CARRIER SAFETY!

IMPORTANT MESSAGE

Any enforcement actions taken against you and any subsequent court actions are intended to secure compliance with the traffic laws and all other users of the highways. Failure to comply with your written promise to appear in court as made on this citation will constitute a separate offense with which you may be charged and result in warrants being issued for your arrest. The issuance of arrest warrants will make you subject to entry into the wanted persons file of this Department. Failure to appear in court or failure to pay or satisfy a fine or judgment in the manner ordered by the court may result in the denial of renewal of your driver's license.

You may be able to require that this charge (Violation of Chapter 545, Transportation Code - Operation and Movement of Vehicles) be dismissed by taking a driving safety course. However, you will lose that right if you do not provide written notice to the court on or before your appearance date of your desire to do so.

"A second or subsequent conviction of an offense under the Texas Motor Vehicle Safety Responsibility Act will result in the suspension of your driver's license and motor vehicle registration unless you file and maintain evidence of financial responsibility with the Department of Public Safety for two (2) years from the date of conviction. The department may waive the requirement to file evidence of financial responsibility if you file satisfactory evidence with the department showing that at the time this citation was issued, the vehicle was covered by a motor vehicle liability insurance policy or that you were otherwise exempt from the requirements to provide evidence of financial responsibility."

CES ENVIRONMENTAL SERVICES, INC.

BANK OF AMERICA 35-2/1130 - 4339 26173

4904 GRIGGS ROAD HOUSTON, TEXAS 77021 (713) 676-1460

2/12/2007

PAY TO THE ORDER OF _

Judge Henry A Welfel

\$ **139.00

One Hundred Thirty-Nine and 00/100**

DOLLARS 🔂 🧱

Judge Henry A Welfel 104 Teakwood Ste 3 Victoria, TX. 77901

MEMO

CP # 0151818

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(b) (4

26173

CES ENVIRONMENTAL SERVICES, INC.

Judge Henry A Welfel

Date 2/8/2007 Type Bill

Reference CP # 0151818 Original Amt. 139.00 2/12/2007 Balance Due Discount 139.00

Check Amount

Payment 139.00 139.00

CES Environmental S CP # 0151818

139.00



Equipment and Facility Work Order

| Equipment Number or Description | | CES Customer and Job (for customer damage only) | | | | |
|----------------------------------|---------------|---|--|--|--|--|
| | _ | | | | | |
| | | | | | | |
| Equipment Type or Area | | | | | | |
| | · | | | | | |
| Description of Job | | | | | | |
| | | | | | | |
| | | - | | | | |
| Description of Work Preformed | Cost of Parts | Labor Hours Worker | | | | |
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| Complete Dut Stares | 604 | 55°= | | | | |
| PAR LATE THE KIGHT COLL . | | | | | | |
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| 1 2.1.c, Sugar | 1.56 | | | | | |
| Total Cost for Parts \$656 | | | | | | |
| Total Labor (hours x \$55.00) \$ | | | | | | |

White - Equipment and Maintenance Files

Goldenrod - Customer Service (If Applicable)

Justice Courts, Victoria County, Texas

Precinct 1 Judge Annie Ramos

3506 N. Ben Wilson, Suite E, Victoria, TX 77901

(361) 573-0836 Fax (361) 573-1835

Precinct 3

Judge Robert "Bob" Whitaker 111-A N. Glass, Victoria, TX 77901 (361) 575-0246

Fax (361) 575-1202

Judge Stuart Posey

Precinct 2 6605-C N. Navarro, Victoria, TX 77904

(361) 575-0012

2-23-07

Fax (361) 573-5515

Precinct 4 Judge Hank Welfei

104 Teakwood, Suite 3, Victoria, TX 77901

(361) 573-5073 Fax (361) 572-0441

This letter is furnished as a courtesy to you by the Justice Courts of Victoria County, Texas to assist you in making disposition of the charge or charges filed against you. You may have the right to have the violation dismissed by completing a driving safety course, but you must contact the court for information concerning this procedure on or before the court date on your ticket.

- IF YOU WISH TO ENTER A PLEA OF GUILTY OR NOLO CONTENDERE, please so indicate below in the proper space provided. A plea of Nolo Contendere means that you do not contest the state's charges against you. The fine for a Nolo Contendere is the same as that for a plea of Guilty. Either plea indicates that you agree to waive appearance before the Court for trial.
- You must refer to the schedule shown on the reverse side of this letter to determine the total amount of your fine(s) and costs assessed against you. Make your remittance by Cashier's Check or Money Order (PERSONAL CHECK NOT ACCEPTED) to the Justice Court circled at the top of this letter. Return your copy of the Citation and this letter with your remittance to assure proper credit.



PLEASE CONTACT PROPER COURT FOR CREDIT CARD PAYMENT.



- IF YOU WISH TO ENTER A PLEA OF NOT GUILTY and desire a trial, you must so indicate in the proper space provided below. You shall be notified by mail of the court date set for your hearing. You have the right to a trial by jury, if you so request. You also have the right to be represented by an Attorney, however, there is no right to a court appointed attorney in these Class C misdemeanors.
- IF YOU FAIL TO RESPOND TO THIS CHARGE BY THE APPEARANCE DATE SHOWN ON THE CITATION, AN ADDITIONAL CHARGE MAY BE ASSESSED AGAINST YOU FOR FAILURE TO APPEAR AND A WARRANT ISSUED FOR YOUR ARREST, WHICH WILL RESULT IN ANOTHER \$264.00 FINE AND COSTS.
- If additional information is needed, call the number above. IT IS YOUR RESPONSIBILITY TO CONTACT THE COURT AND NOT THE COURTS RESPONSIBILITY TO CONTACT YOU.

Thank You. The Justice Courts, Victoria County, Texas

"A conviction of an offense under a traffic law of this state or a political subdivision of this state may result in the assessment on your driver's Ilcense of a surcharge under the Driver Responsibility Program.

REPLY FORM

Mail to the Justice Court circled at the top of this letter.

Check one:

| 1 | I hereby enter a plea of GUILTY and waive appearance at tria | l. | | | |
|---|--|-----------|-----------|-----------|-------|
| | Cashier's Check or Money Order (Company check accepted | d) in the | amount of | the fine(| s) is |
| | enclosed. | | | | |

| 2 | I hereby enter a plea of NOLO CONT | ENDERE and waive appear | rance for trial. | |
|---|------------------------------------|-------------------------|----------------------------|-------|
| | Cashier's Check or Money Order (C | ompany check accepted) | in the amount of the fine(| s) is |
| | enclosed. | | | • |

| 3 | I hereby enter | a plea of NOT | GUILTY | and | request | (jury) | (non-jury) | trial for | each charge | filed |
|---|----------------|---------------|--------|-----|---------|--------|------------|-----------|-------------|-------|
| | against me. | | | | | | | | | |

| 4 | I wish to take | D - f 1 | Dat. 1 | 101 | | Sec 4 |
|----|-------------------|-----------|-----------------|---------|-----------|-------|
| 4 | I WISH TO TAKE | Detensive | Driving | PIDAGO | CONTRACT | COLID |
| ** | 1 111011 (0 10110 | 00.010170 | - 11 V II / IQ. | (ICCCC | COLICE U. | |

| | | 74.4 | | |
|-------|-----------------|------|------|--|
| Date: | Signature:_ | | | |
| | • | • | | |

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| ☐ ARREST TKT ☐ 9 ~ 15 PASS. FOR HIRE ☐ COM. VEH. ☐ 16 PASS. FOR HIRE ☐ ACCIDENT ☐ 16 PASS. NOT FOR HIRE | CONSTRUC | TION ZONE PIXED PROADSIDE ALCHI DS |
| ☐ ACCIDENT ☐ 16 FASS. NOT FOR HIRE ☐ CDL ☐ SCHEDULE ☐ CHARTER | ☐ INTRASTATE ☐ YES | M NO SCALE — — |
| DATE: 02/13/2007 TIME: 10 | 0:48 AM COUNTY: CHAMBERS 'HP | WY: (1) IH-0010 IN CHAMBERS CO. (7! M.P.#: 815 |
| LESSEE/MC: C E S ENVIROMENTAL SERVICES | | USDOT#: 0869392 |
| Annual Control of the | ILMOBILE) HOUSTON TX 77013 | ICC/MC#: 400234 |
| OWNER: STEVEN K STRICKER ADD/CITY/ST/ZIP: (b) (4) | | TXDOT#: 005516524C |
| OPERATOR: ROBERT JOE HICKMAN | RACE/SEX: BM | PHONE#: 7136761460 DOB: (b) (4) MED CARD: 08-03-07 |
| ADD/CITY/ST/ZIP: (D) (4) | | DL # (b) (4) ST: TX DL CLASS: A |
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| SIGNATURE: | | |
| I HEREBY PROMISE TO APPEAR AT THE TIME AND PLACE DESIGNATED IN THIS NOTICE. (THIS IS | ם | |
| NOT A PLEA OF GUILTY) | X 00 0 0 | |
| COPY RECEIVED BY | GROSS WEIGHT: | GROUP WEIGHT: |
| YOU ARE HEREBY NOTIFIED TO APPEAR | | LOAD DISP: |
| JUDGE: COURT: | PCT./PLACE: | PERMIT #: |
| PHONE: ON/BEFORE ADDRESS: | AT | RG WT #1 90000 GVWR #1 RG WT #2 GVWR #2 |
| SEAL #'S REMOVED: DEPT. SEAL #; INST | TALLED CVSA DECAL-TT CVSA DE | |
| BEAL # 3 KENOVED. DEFI. JEAL #, INJ. | CVSA DECRETT CVSA DE | ECAL-ST CVSA DECAL-ST : |
| SEAL # 3 ABMOVED. SEET, SEAL #, INS | CVOR DECRETT CVOR DE | ELAL-ST CVSA DECAL-ST |
| SHIPPING #: 2162278 | CONSIGNOR: KINDER MORGAN | CONSIGNEE: CHEMICAL WASTE MANAGEMENT |
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| SHIPPING #: 2162278 COMMODITY: HAZARDOUS WASTE | CONSIGNOR: KINDER MORGAN ORIGIN: PASADENA NO PLACARDS REQ? | CONSIGNEE: CHEMICAL WASTE MANAGEMENT |
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ANY ENTRIES IN THE VIOLATIONS' SECTION OF DRIVER'S COPY, WHERE THERE IS "YES" IN THE TICKET BOX, INDICATES CHARGES FILED AGAINST THE DRIVER. THIS WILL REQUIRE CONTACTING THE JUDGE FOR APPROPRIATE DISPOSITION.

JUDGE INFORMATION IS IN HEAVY BORDERED BOX ON DRIVER'S COPY.

PAYMENTS FOR FINES SHOULD BE SENT TO THE COURT LISTED ON THE DRIVER'S COPY.

DO NOT SEND PAYMENTS TO TX DPS/MCB.

CERTIFICATION OF REPAIRMAN I CERTIFY THAT THE REQUIRED REPAIRS SHOWN IN THE "OUT OF SERVICE" COLUMN ON THE OTHER SIDE OF THIS CERTIFICATE HAVE BEEN SATISFACTORILY COMPLETED. SIGNATURE OF REPAIRMAN: REPAIR WORK COMPLETED NAME OF SHOP (GARAGE): DATE: TIME: MOTOR CARRIER CERTIFICATION OF ACTION TAKEN I CERTIFY THAT ALL VIOLATIONS NOTED UPON THIS REPORT HAVE BEEN CORRECTED AND ACTION HAS BEEN TAKEN TO ASSURE COMPLIANCE WITH THE MOTOR CARRIER SAFETY REGULATIONS INSOFAR AS THEY ARE APPLICABLE TO MOTOR CARRIERS AND DRIVERS. SIGNATURE OF CARRIER OFFICIAL: TITLE: DATE: 2-14-07 HISE Manager

ATTENTION DRIVER:

This report must be furnished to the motor carrier whose name appears on this report.

ATTENTION DRIVER:

TRC Chapter 644, Revised Statutes, requires the Motor Carrier to execute the above certification

and return this report to: MOTOR CARRIER BUREAU

TEXAS DEPARTMENT OF PUBLIC SAFETY

PO BOX 4087

AUSTIN TX 78773-0521

IMPORTANT MESSAGES

Any enforcement actions taken against you and any subsequent court actions are intended to secure compliance with the traffic laws and all other users of the highways. Failure to comply with your written promise to appear in court as made on this citation will constitute a separate offense with which you may be charged and result in warrants being issued for your arrest. Failure to appear in court or failure to satisfy a judgement ordering payment of a fine and cost in the manner ordered by the court may result in the denial of renewal of your driver's license.

"A second or subsequent conviction of failure to maintain financial responsibility will result in the suspension of your driver license and motor vehicle registration unless you file and maintain proof of financial responsibility with the Department of Public Safety for two (2) years from the date of conviction. The Department may waive the requirements to file proof of financial responsibility if you file satisfactory evidence with the Department showing that at the time this citation was issued the vehicle was covered by a liability insurance policy or that you were otherwise exempt from the requirements to provide evidence of financial responsibility.

You may be able to require that this charge be dismissed by successfully completing a driving safety course or a motorcycle operator training course. You will lose that right if, on or before your appearance date, you do not provide the court with notice of your request to take the course. This article does not apply to an offense committed by a person who holds a commercial driver's license.

"A conviction of an offense under a traffic law of this state or a political subdivision of this state may result in the assessment on your driver's license of a surcharge under the Driver Responsibility Program."

A request for an out-of-service review, regarding operating authority, must be made in writing and forwarded to the manager of the Motor Carrier Bureau. If requested, a review will be scheduled and conducted by the manager of the Motor Carrier Bureau or the director's designee within 10 days of the issuance of the out-of-service order. A request for review should be addressed to the Texas Department of Public Safety, Motor Carrier Bureau, P.O. Box 4087, Austin, TX 78773-0521 or may be sent by facsimile transmission to (512) 424-5712 or via electronic mail at MotorCarrierBureau@txdps.state.tx.us. The Department may conduct the review by telephone conference call.

To obtain a TxDOT Motor Carrier Insurance Certificate or Single State Registration - contact the Texas Department of Transportation at 1-800-299-1700 or visit their website at www.dot.state.tx.us.

To obtain a USDOT Number contact the Federal Motor Carrier Safety Administration at 1-800-832-5660 or visit their website at www.fmcsa.dot.gov/factsfigs/formspubs.htm.

To obtain IFTA information contact the State of Texas Comptrollers Office at 1-800-252-1383 or visit their website at www.window.state.tx.us/taxinfo/fuels/ifta.html.

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CERTIFICATION OF REPAIRMAN

I CERTIFY THAT THE REQUIRED REPAIRS SHOWN IN THE "OUT OF SERVICE" COLUMN ON THE OTHER SIDE OF THIS CERTIFICATE HAVE BEEN SATISFACTORILY COMPLETED.

SIGNATURE OF REPAIRMAN:

NAME OF SHOP (GARAGE):

REPAIR WORK COMPLETED

DATE:

TIME:

MOTOR CARRIER CERTIFICATION OF ACTION TAKEN

I CERTIFY THAT ALL VIOLATIONS NOTED UPON THIS REPORT HAVE BEEN CORRECTED AND ACTION HAS BEEN TAKEN TO ASSURE COMPLIANCE WITH THE MOTOR CARRIER SAFETY REGULATIONS INSOFAR AS THEY ARE APPLICABLE TO MOTOR CARRIERS AND DRIVERS.

SIGNATURE OF CARRIER OFFICIAL:

DATE:

2-26-07

HSE Manager

ATTENTION DRIVER:

This report must be furnished to the motor carrier whose name appears on this report.

ATTENTION DRIVER:

TRC Chapter 644, Revised Statutes, requires the Motor Carrier to execute the above certification and return this report to:

MOTOR CARRIER BUREAU

TEXAS DEPARTMENT OF PUBLIC SAFETY

PO BOX 4087 AUSTIN TX 78773-0521

IMPORTANT MESSAGES

Any enforcement actions taken against you and any subsequent court actions are intended to secure compliance with the traffic laws and all other users of the highways. Failure to comply with your written promise to appear in court as made on this citation will constitute a separate offense with which you may be charged and result in warrants being issued for your arrest. Failure to appear in court or failure to satisfy a judgement ordering payment of a fine and cost in the manner ordered by the court may result in the denial of renewat of your driver's license.

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You may be able to require that this charge be dismissed by successfully completing a driving safety course or a motorcycle operator training course. You will lose that right if, on or before your appearance date, you do not provide the court with notice of your request to take the course. This article does not apply to an offense committed by a person who holds a commercial driver's license.

"A conviction of an offense under a traffic law of this state or a political subdivision of this state may result in the assessment on your driver's license of a surcharge under the Driver Responsibility Program."

A request for an out-of-service review, regarding operating authority, must be made in writing and forwarded to the manager of the Motor Carrier Bureau. If requested, a review will be scheduled and conducted by the manager of the Motor Carrier Bureau or the director's designee within 10 days of the issuance of the out-of-service order. A request for review should be addressed to the Texas Department of Public Safety, Motor Carrier Bureau, P.O. Box 4087, Austin, TX 78773-0521 or may be sent by facsimile transmission to (512) 424-5712 or via electronic mail at MotorCarnerBureau@txdps.state.tx.us. The Department may conduct the review by telephone conference call.

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STATE OF LOUISIANA **DEPARTMENT OF TRANSPORTATION AND DEVELOPMENT** Weights & Standards, Enforcement & Permits Office P.O. Box 94042 / 1201 Capitol Access Road Baton Rouge, Louisiana 70804-9042



www.dotd.louisiana.gov

CES ENVIRONMENTAL SVC 4904 GRIGGS ROAD HOUSTON, TX 77021

April 4, 2007

Dear Sir or Madam:

Please refer to Violation Ticket Number 0701BE-44.BJ00153, in the amount of \$296.00, issued on 02/07/2007.

The Violation Ticket Review Committee met for your VT and based on the facts and documentation you submitted to said meeting, this ticket was ruled valid.

Louisiana Revised Statute requires that this ticket be paid within thirty (30) days of receipt or ruling by VTRC. This is to advise you that if we do not receive a request for further review or payment for the fine amount of the Violation Ticket within thirty (30) from the date of this letter, the ticket will be forwarded to our Legal Section for collection. LADOTD may have the LA vehicle operator's license suspended, or renewal or re-issuance or the license denied, or both. If your payment has already been submitted, no further action is required.

In accordance with R.S. 32:389(C)(2), payment must be made by either Certified Check, Cashier's Check, or Money Order made payable to LA DOTD. Visa, MasterCard and American Express credit Spoke to Mins. Herdenson

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Spoke to Mins. Her cards will also be accepted by calling (225)377-7100.

Sincerely yours,

Janice P. Williams, P.E. Chief, Systems Engineering Division

STEVEN K STRICKER

STEVEN K STRICKER

JPW:dmm

CC:

AN EQUAL OPPORTUNITY EMPLOYER A DRUG-FREE WORKPLACE

weight ticket ?



STATE OF LOUISIANA DEPARTMENT OF TRANSPORTATION AND DEVELOPMENT Weights & Standards, Enforcement & Permits Office P.O. Box 94042 / 1201 Capitol Access Road Baton Rouge, Louisiana 70804-9042



www.dotd.louisiana.gov

CES ENVIRONMENTAL SVC 4904 GRIGGS ROAD HOUSTON, TX 77021 February 28, 2007

To Whom It May Concern:

We received your protest letter concerning Violation Ticket Number 0701BE-44.BJ00153.

Your VT has been scheduled for review on 03/13/2007. You will receive written notification of the Violation Ticket Review Committee's ruling 10 (ten) days following your review date. No payment of the fine is required at this time.

If you have made prior arrangements to appear in person for a second review, please contact my secretary at least two (2) weeks prior to review date. You will be given the time and location of the meeting. Please plan to bring any additional or new information that you may have concerning this matter.

Sincerety yours,

Denny J. Silvio

DOTD Weights and Standards Administrator

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DJS:dmm

CANDIDO A ROSALES

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AN EQUAL OPPORTUNITY EMPLOYER
A DRUG-FREE WORKPLACE

form: eTicketO

Louisiana Department of Transportation and Development

Attn: Weights & Standards Office P.O. Box 94042, Baton Rouge, LA, 70804-9042

Issued the 7th day of February, 2007 at 01:34 PM Highway: I-10 E Parish: Calcasieu VT# 0701BE-44.BJ00153(0) Last Name: ROSALES. First Name: CANDIDO M.I. A Suffix: City (D) Operator License Number: Class: A State of Issue: TX D.O.E DBA Owner Name: STEVEN K STRICKER Name: Street Address: City: , ZIP: State: Phone: Phone D 4 Vehicle Information Is Apportioned Venicle VIN Number Vehicle D.O.T number Vehicle Make Vehicle Year 869392 2007 PTR8 Registered Weight License Number License Year License State 80.000 2007 TX Primary Trailer Information 2nd Trailer Information 2nd Trailer License No Primary Trailer License No 2nd Trailer State Primary Trailer State W19909 NA NA Permit Information Valid 48 Hour Permit No. Expired 48 Hour Permit No. Expired Permit No. Valid Permit No. Permitted Weight: Control Number: Commodity Code Description Other WASTE R.S. No. Violation: Description 32:386 1. Over Legal Gross Vehicle Weight or Over Legal Axle Weight \$0.00 Type: Type 8 Tire width on steering axle: 11.00 No. Of Axles Sets: 3 Maximum allowable legal / permitted weight - Interstate: 83400 Non-Interstate: 88000 Axle Set Axle Set 1 Axle Set 2 Axle Set 3 Steering Axle Tandem Tridum Type 15,000 34,000 42,000 Legal Weight Scale Weight 11,680 21,200 47,920 Over Weight 0 5,920 \$0.00 \$0.00 \$296.00 Fine Weight Table Fine Summary **GVW Overage** Primary Fine G.V.W. Over GVW lb Over GVW \$ Individual Axle Fines Multiple Violation 80,800 \$0.00 \$296.00 \$296.00 \$0.00 Remarks: Driver was given the opportunity to shift, but was unable to legalize Total Fine Is: \$296.00 Violation Number: 0701BE-44.BJ00153(0) renda 7. Jennings Driver CANDIDO A ROSALES

Officer

Brenda F Jennings

Immediate payment may be made by the following options: MasterCard, Visa, or American Express Credit Cards, LA DOTD Approved Money Transfers, Posted Bond, Cash, Cashier's Check, Certified Check, Company Checks or Money Order made payable to LA DOTD. For information related to payment, please call (225) 377-7100.

Violation Tickets must be paid or protested as set forth in [1] and [3] within thirty (30) days of the issuance date on the VT. In the event payment of the fine has not received within 30 days, LA operators license information will be forwarded to the Motor Vehicle Division, Dept. of Public Safety for suspension, revocation, and cancellation; and the vehicle plate will be removed until the fine is paid.

Written protest of a Violation Ticket must be submitted within 30 days of issuance date. Upon receipt of a written protest, the VT will be scheduled for review in the regularly scheduled meetings of the Violation Ticket Review Committee. If additional information concerning protesting is needed, Please call (225) 377-7131.

LA DOTD Weights and Standards PO Box 94042 Baton Rouge, LA 70804-9042

0701BE-44.BJ00153(0)

According to Louisiana Revised Statute 32:389, paragraphs 4 (a) (b) and (c) and 5:

"Any owner or driver resisting the payment of the penalty found due, or the enforcement of any provision of this Part In relation thereto, shall pay the amount of the penalty assessed to the Weights and Standards police officer, state policeman or other person designated in a license receipt and shall give this officer, state policeman or person notice at the time of payment of his intention to file suit for the recovery of such penalty."

"Any owner or driver who pays an assessed penalty under protest in accordance with the provisions of this Section shall have a period of ninety days after the date of payment to institute a civil suit against the department to recover the penalty so paid."

"The right to sue for recovery of a penalty paid under protest shall afford a legal remedy and right of action in any state district court for a full and complete adjudication of any questions arising in the enforcement of a penalty respecting the legality of any penalty assessed or the method of enforcement thereof. Any such suit may be instituted either in the parish in which the violation occurred, the domicile of vehicle, provided the domicile is within the state of Louisiana, or in East Baton Rouge Parish. In any such suit, service of process shall be made on the Department, through the Secretary. The department shall be a necessary and proper party defendant in any such suit.

"No court of this state shall issue any process whatsoever to restrain the collection of any penalty assessed by the department pursuant to this Part."

VIOLATION TICKET DOTD 03-44-0699 (REV. 09/01)

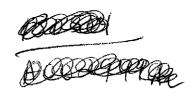
Amount Enclosed:

Please cut and include this stub with your payment Louisiana Department of Transportation and Development Attn: Weights & Standards Office P.O. Box 94042, Baton Rouge, LA. 70804-9042 Issued to DRA Owner CANDIDO A ROSALES STEVEN K STRICKER Operator License Number (b) (4) Class: A State of Issue: TX D.O.B Violation Ticket Issued the 7th day of February, 2007 at 01:34 PM Highway: O.B. (b) (4) Vehicle D.O.T. **869392** Highway: I-10 E. Parish: Calcasieu Revised Statute Number Description 32:386 1. Over Legal Gross Vehicle Weight or Over Legal Axle Weight Your Total Fine Is: \$296.00 Violation Number: 0701BE-44.BJ00153(0)

Date:

Payment Type:

869392



STATE OF LOUISIANA DEPARTMENT OF TRANSPORTATION AND DEVELOPMENT CALCASIEU PARISH I-10 EAST BOUND

DATE: Feb 07 2007 TIME: 01:24:38pm

Weighment 1: 11680 lb Scale 1

21200 lb Scale 2 Weighment 2: 5920

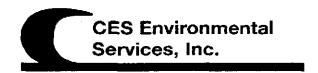
Scale 3 Weighment 3: 47920 lb

TOTAL: 80800 lb

> JOOMEY STricker TXR85ZIZ 8

80800 lb. TOTAL:

EPAHO042001244



February 8, 2007

Ms. Deanna Mitchell
Louisiana Department of Transportation and Development
Attn: Weights & Standards Office
P.O. Box 94042
Baton Rouge, LA 70804-9042

Dear Ms. Mitchell

Attached is a copy of violation number: 0701BE-44.BJ00153(0) issued to our driver Candido Rosales on 2-7-07. I am writing to request you to reduce the fine amount, if it cannot be waived altogether. We are a small company and do our best to be compliant.

Looking forward to hearing from you.

Robbeh Rhangina_

Thanking you,

Sincerely,

Prabhakar R. Thangudu

HSE Manager

CES Environmental Services, Inc.

4904 Griggs Road

Houston, TX 77021

713-676-1460

pthangudu@cesenvironmental.com



STATE OF LOUISIANA DEPARTMENT OF TRANSPORTATION AND DEVELOPMENT Weights & Standards, Enforcement & Permits Office P.O. Box 94042 / 1201 Capitol Access Road Baton Rouge, Louisiana 70804-9042



www.dotd.louisiana.gov

CANDIDO A ROSALES 7554 THUROW ST HOUSTON, TX 77087 February 28, 2007

To Whom It May Concern:

We received your protest letter concerning Violation Ticket Number 0701BE-44.BJ00153.

Your VT has been scheduled for review on 03/13/2007. You will receive written notification of the Violation Ticket Review Committee's ruling 10 (ten) days following your review date. No payment of the fine is required at this time.

If you have made prior arrangements to appear in person for a second review, please contact my secretary at least two (2) weeks prior to review date. You will be given the time and location of the meeting. Please plan to bring any additional or new information that you may have concerning this matter.

Sincerely yours,

Denny J. Silvio

DOTD Weights and Standards Administrator

STEVEN K STRICKER

ec: (b) (4)

CES ENVIRONMENTAL SVC 4904 GRIGGS ROAD HOUSTON, TX 77021

DJS:dmm

AN EQUAL OPPORTUNITY EMPLOYER
A DRUG-FREE WORKPLACE

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| applied to these vehicles or operate such detects have been repaired and the vehicl condition, or proper operating authority | es have been restored to | or service safe operating | Out of Service. No permit or require operate any motor | driver to dri | ve or Repair Se | Scorted to ervice |
| SEE CONTINUATION SHEET | ····· | | operate any motor | AGUICIE (UII) | U. Unknow N. Driver | m |
| CASE: 07-9375 CLASS A CDL 5'08' | TROOPER COMMENTS MED BLD BRN/ BRN | /// END: TX | | | | |
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JUDGE INFORMATION IS IN HEAVY BORDERED BOX ON DRIVER'S COPY.

PAYMENTS FOR FINES SHOULD BE SENT TO THE COURT LISTED ON THE DRIVER'S COPY.

DO NOT SEND PAYMENTS TO TX DPS/MCB.

CERTIFICATION OF REPAIRMAN I CERTIFY THAT THE REQUIRED REPAIRS SHOWN IN THE "OUT OF SERVICE" COLUMN ON THE OTHER SIDE OF THIS CERTIFICATE HAVE BEEN SATISFACTORILY COMPLETED. SIGNATURE OF REPAIRMAN: NAME OF SHOP (GARAGE): REPAIR WORK COMPLETED DATE: TIME:

I CERTIFY THAT ALL VIOLATIONS NOTED UPON THIS REPORT HAVE BEEN CORRECTED AND ACTION HAS BEEN TAKEN TO ASSURE COMPLIANCE WITH THE MOTOR CARRIER SAFETY REGULATIONS INSOFAR AS THEY ARE APPLICABLE TO MOTOR CARRIERS AND DRIVERS.

SIGNATURE OF CARRIER OFFICIAL: TITLE: DATE:

| SIGNATURE OF | CARRIER C | ILL(CIME) |
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HSE Marager

4-12-07

ATTENTION DRIVER:

This report must be furnished to the motor carrier whose name appears on this report.

ATTENTION DRIVER:

TRC Chapter 644, Revised Statutes, requires the Motor Carrier to execute the above certification

and return this report to: MOTOR CARRIER BUREAU

TEXAS DEPARTMENT OF PUBLIC SAFETY

PO BOX 4087

AUSTIN TX 78773-0521

IMPORTANT MESSAGES

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STATE OF LOUISIANA **DEPARTMENT OF TRANSPORTATION AND DEVELOPMENT** Weights & Standards, Enforcement & Permits Office P.O. Box 94042 / 1201 Capitol Access Road Baton Rouge, Louisiana 70804-9042



www.dotd.louisiana.gov



STEVEN K STRICKER

April 4, 2007

Dear Sir or Madam:

Please refer to Violation Ticket Number 0701BE-44.BJ00153, in the amount of \$296.00, issued on 02/07/2007.

The Violation Ticket Review Committee met for your VT and based on the facts and documentation you submitted to said meeting, this ticket was ruled valid.

Louisiana Revised Statute requires that this ticket be paid within thirty (30) days of receipt or ruling by VTRC. This is to advise you that if we do not receive a request for further review or payment for the fine amount of the Violation Ticket within thirty (30) from the date of this letter, the ticket will be forwarded to our Legal Section for collection. LADOTD may have the LA vehicle operator's license suspended, or renewal or re-issuance or the license denied, or both. If your payment has already been submitted, no further action is required.

In accordance with R.S. 32:389(C)(2), payment must be made by either Certified Check, Cashier's Check, or Money Order made payable to LA DOTD. Visa, MasterCard and American Express credit cards will also be accepted by calling (225)377-7100.

Sincerely.mours.

Janice P. Williamst

Chief, Systems Engineering Division

CC:

CES ENVIRONMENTAL SVC 4904 GRIGGS ROAD HOUSTON, TX 77021

JPW:dmm

AN EQUAL OPPORTUNITY EMPLOYER A DRUG-FREE WORKPLACE

| TX072Z0AQN04 | TXDPS COMMERCIAL VEHICLE ENFORCEMENT CP#: 0151818 |
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| ☑ COM, VEH. ☐ 16 PASS. FOR HIRE | CONSTRUCTION ZONE ☐FIXED ☑ROADSIDE SP PROG: ☑ INTERSTATE ☐ TO ☐ ALCH ☐ DS |
| ☐ ACCIDENT ☐ 16 PASS. NOT FOR HIRE ☐ CDL ☐ SCHEDULE ☐ CHARTER | SP PROG: INTERSTATE YES NO SCALE SW TE |
| DATE: 04/17/2007 TIME: | 8:29 AM COUNTY: NACOGDOCHES HWY: (2) US-0059 IN NACOGDOCHES CO. M.P. *: 376 |
| LESSEE/MC: C E S ENVIROMENTAL SERVICES | : USDOT#: 0069392 |
| ADD/CITY/ST/ZIP: 4904 GRIGGS RD (3901 TR) | ALLMOBILE) HOUSTON TX 77013 ICC/MC#: 400234 |
| OWNER: STEVEN STRICKER | TXDOT#: 005516524C |
| ADD/CITY/ST/ZIP: (b) (4) | PHONE#: 7136761460 |
| OPERATOR: DAVID F VANDENBERG | RACE/SEX: WAM DOB: (b) (4) MED CARD: 02/24/08 |
| ADD/CITY/ST/ZIP: (b) (4) | DL #: (b) (4) ST: TX DL CLASS: A |
| VEH SEARCH: ☐ YES ☑ NO REASON FO | R STOP: WARN CITATION INSPECTION CONTRABAND LOCATED: YES NO |
| TYPE OF SEARCH: CONSENT PC INC. T | O ARREST INVENTORY TYPE OF CONTRABAND: DRUGS WEAPONS CURRENCY OTHER |
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| NOT A PLEA OF GUILTY) | X(0)00(0)00(0) |
| COPY RECEIVED BY | GROSS WEIGHT: 0 GROUP WEIGHT: 0 |
| YOU ARE HEREBY NOTIFIED TO APPEAR | LOAD DISP: |
| JUDGE: COURT: | PCT./PLACE: PERMIT #: |
| PHONE: ON/BEFORE | AT RG WT #1 80000 GVWR #1 |
| ADDRESS: | RG WT #2 0 GVWR #2 |
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| TICRET VIOL. CITE # Unit OOS OOS POST No. Y/N DISP ACC | VIOLATIONS DISCOVERED DRIVER: PLEASE COMPLY WITH DIRECTIONS ON BACK SIDE OF THIS FORM |
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| | VEHICLE/DRIVER OUT OF SERVICE NOTICE |
| Of Service, the Adultiela Mith delects for Tower | hapter 644 I hereby declare "Out DRIVER Pursuant to authority contained in OOS DISPOSITIONS by "YES" in the Out of Service TRC Chapter 644 I hereby notify and A. Repaired at Scene / |
| column of this report. No person shall remove t | he out of service stickers declare the driver named on this report Obtained Oper. Auth. es until the out of service Out of Service. No motor carrier shall B. Towed/Escorted to |
| defects have been repaired and the vehicles have condition, or proper operating authority has bee | n obtained. permit or require driver to drive or kepair Service operate any motor vehicle until D. Other |
| SEE CONTINUATION SHEET TROOPER COMMENTS | N. Driver 003 |
| TEST YES VIN 2889 NO VIOLATIONS FOUNT VAN TRAILER | CHECKED BLOCK AND BRACE IN |
| | Log Book Exemption |
| | COPY RECEIVED BY |
| Thot sould str | N/DISTRICT/AREA TIME COMPLETED REPORT PREPARED BY: HOPSON, RAYMOND LEAMON REFERRAL ID |
| HOPSON, RAYMOND LEAMON 05: | 664 2 A 06 9:08AM REFERRAL ID BRAKES INSPECTED BY: |
| CUMVARS ETPED DI! | |

ANY ENTRIES IN THE VIOLATIONS' SECTION OF DRIVER'S COPY, WHERE THERE IS "YES" IN THE TICKET BOX, INDICATES CHARGES FILED AGAINST THE DRIVER. THIS WILL REQUIRE CONTACTING THE JUDGE FOR APPROPRIATE DISPOSITION.

JUDGE INFORMATION IS IN HEAVY BORDERED BOX ON DRIVER'S COPY.

PAYMENTS FOR FINES SHOULD BE SENT TO THE COURT LISTED ON THE DRIVER'S COPY.

DO NOT SEND PAYMENTS TO TX DPS/MCB.

CERTIFICATION OF REPAIRMAN I CERTIFY THAT THE REQUIRED REPAIRS SHOWN IN THE "OUT OF SERVICE" COLUMN ON THE OTHER SIDE OF THIS CERTIFICATE HAVE BEEN SATISFACTORILY COMPLETED. SIGNATURE OF REPAIRMAN: NAME OF SHOP (GARAGE): REPAIR WORK COMPLETED DATE: TIME:

CERTIFY THAT ALL VIOLATIONS NOTED UPON THIS REPORT HAVE BEEN CORRECTED AND ACTION HAS BEEN TAKEN TO ASSURE COMPLIANCE WITH THE MOTOR CARRIER SAFETY REGULATIONS INSOFAR AS THEY ARE APPLICABLE TO MOTOR CARRIERS AND DRIVERS.

SIGNATURE OF CARRIER OFFICIAL: TITLE:

DATE: 4-23-07

ATTENTION DRIVER:

This report must be furnished to the motor carrier whose name appears on this report.

ATTENTION DRIVER:

TRC Chapter 644, Revised Statutes, requires the Motor Carrier to execute the above certification

and return this report to: MOTOR CARRIER BUREAU

TEXAS DEPARTMENT OF PUBLIC SAFETY

PO BOX 4087

AUSTIN TX 78773-0521

IMPORTANT MESSAGES

Any enforcement actions taken against you and any subsequent court actions are intended to secure compliance with the traffic laws and all other users of the highways. Failure to comply with your written promise to appear in court as made on this citation will constitute a separate offense with which you may be charged and result in warrants being issued for your arrest. Failure to appear in court or failure to satisfy a judgement ordering payment of a fine and cost in the manner ordered by the court may result in the denial of renewal of your driver's license.

"A second or subsequent conviction of failure to maintain financial responsibility will result in the suspension of your driver license and motor vehicle registration unless you file and maintain proof of financial responsibility with the Department of Public Safety for two (2) years from the date of conviction. The Department may waive the requirements to file proof of financial responsibility if you file satisfactory evidence with the Department showing that at the time this citation was issued the vehicle was covered by a liability insurance policy or that you were otherwise exempt from the requirements to provide evidence of financial responsibility.

You may be able to require that this charge be dismissed by successfully completing a driving safety course or a motorcycle operator training course. You will lose that right if, on or before your appearance date, you do not provide the court with notice of your request to take the course. This article does not apply to an offense committed by a person who holds a commercial driver's license.

"A conviction of an offense under a traffic law of this state or a political subdivision of this state may result in the assessment on your driver's license of a surcharge under the Driver Responsibility Program."

A request for an out-of-service review, regarding operating authority, must be made in writing and forwarded to the manager of the Motor Carrier Bureau. If requested, a review will be scheduled and conducted by the manager of the Motor Carrier Bureau or the director's designee within 10 days of the issuance of the out-of-service order. A request for review should be addressed to the Texas Department of Public Safety, Motor Carrier Bureau, P.O. Box 4087, Austin, TX 78773-0521 or may be sent by facsimile transmission to (512) 424-5712 or via electronic mail at MotorCarrierBureau@txdps.state.tx.us. The Department may conduct the review by telephone conference call.

To obtain a TxDOT Motor Carrier Insurance Certificate or Single State Registration - contact the Texas Department of Transportation at 1-800-299-1700 or visit their website at www.dot.state.tx.us.

To obtain a USDOT Number contact the Federal Motor Carrier Safety Administration at 1-800-832-5660 or visit their website at www.fmcsa.dot.gov/factsfigs/formspubs.htm.

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| P-3 (Rev. 6/01) | | | 6~ | - may be made | | | DATE | 1 | . S | HOUR | - A- |
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Paid \$511.00 to city of Horden on Marlin

ANY ENTRIES IN THE VIOLATIONS' SECTION OF DRIVER'S COPY INDICATES CHARGES FILED AGAINST THE DRIVER. THIS WILL REQUIRE CONTACTING THE JUDGE FOR APPROPRIATE DISPOSITION. (JUDGE INFORMATION IN HEAVY BORDERED BOX ON DRIVER'S COPY.)

ATTENTION DRIVER: This report must be furnished to the motor carrier whose name appears on this report.

ATTENTION DRIVER: TRC Chapter 644, Revised Statutes, requires the Motor Carrier to execute the below

certification and return this report to: MOTOR CARRIER SAFETY SECTION TEXAS DEPARTMENT OF PUBLIC SAFETY PO BOX 4087 AUSTIN TX 78773-0521

CERTIFICATION OF REPAIRMAN I CERTIFY THAT THE REQUIRED REPAIRS SHOWN IN THE "OUT OF SERVICE" COLUMN ON THE OTHER SIDE OF THIS CERTIFICATE HAVE BEEN SATISFACTORILY COMPLETED. SIGNATURE OF REPAIRMAN: NAME OF SHOP (GARAGE): REPAIR WORK COMPLETED

DATE: MOTOR CARRIER CERTIFICATION OF ACTION TAKEN I CERTIFY THAT ALL VIOLATIONS NOTED UPON THIS REPORT HAVE BEEN CORRECTED AND ACTION HAS BEEN TAKEN TO ASSURE COMPLIANCE WITH THE MOTOR CARRIER SAFETY REGULATIONS INSOFAR AS THEY ARE APPLICABLE TO MOTOR CARRIERS AND DRIVERS. SIGNATURE OF CARRIER OFFICAL: TITLE: 4-12-200 HSE Manager

IMPORTANT MESSAGES

Any enforcement actions taken against you and any subsequent court actions are intended to secure compliance with the traffic laws and all other users of the highways. Failure to comply with your written promise to appear in court as made on this citation will constitute a separate offense with which you may be charged and result in warrants being issued for your arrest. The issuance of arrest warrants will make you subject to entry into the wanted persons file of this department. Failure to appear in court or failure to satisfy a judgement ordering payment of a fine and cost in the manner ordered by the court may result in the denial of renewal of your driver's license.

You may be able to require that this charge (Violations of Chapter 545, Transportation Code - Operation and Movement of Vehicles) be dismissed by taking a driving safety course. However, you will lose that right if you do not provide written notice to the court on or before your appearance date of your desire to do so.

A second or subsequent conviction of failure to maintain financial responsibility will result in the suspension of your driver's license and motor vehicle registration unless you file and maintain proof of financial responsibility with the Department of Public Safety for two (2) years from the date of conviction. The Department may waive the requirement to file proof of financial responsibility if you file satisfactory evidence with the Department showing that at the time this citation was issued the vehicle was covered by a liability insurance policy or that you were otherwise exempt from the requirements to provide evidence of financial responsibility.

A request for an out-of-service review, regarding operating authority, must be made in writing and forwarded to the manager of the Motor Carrier Bureau. If requested, a review will be scheduled and conducted by the manager of the Motor Carrier Bureau or the director's designee within 10 days of the issuance of the out-of-service order. A request for review should be addressed to the Texas Department of Public Safety, Motor Carrier Bureau, P.O. Box 4087, Austin, TX 78773-0521 or may be sent by facsimile transmission to (512)424-5712 or via electronic mail at MotorCarrierBureau@txdps.state.tx.us. The Department may conduct the review by telephone conference call.

To obtain a TXDOT Motor carrier Insurance Certificate or Single State Registration - contact the Texas Department of Transportation at 1-800-299-1700 or visit their website at www.dot.state.tx,us,

To obtain a USDOT Number contact the Federal Motor Carrier Safety Administration at 1-800-832-5660 or visit their website at www.fmcsa.dot.gov/factsfigs/formspubs.htm.

To obtain IFTA information contact the State of Texas Comptrollers Office at 1-800-252-1383 or visit their website at www.window.state.tx.us/taxinfo/fuels/ifta.html.

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| applied to these vehicles or operate such vehicle defects have been repaired and the vehicles have | s until the out of service Out of Ser been restored to safe operating permit or | vice. No motor carrier shall B. Towed/Escorted to require driver to drive or Repair Service |
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| PERRY, BOBBY LYNN 040° CHARGES FILED BY: | | SPECTED BY: |

ANY ENTRIES IN THE VIOLATIONS' SECTION OF DRIVER'S COPY, WHERE THERE IS "YES" IN THE TICKET BOX, INDICATES CHARGES FILED AGAINST THE DRIVER. THIS WILL REQUIRE CONTACTING THE JUDGE FOR APPROPRIATE DISPOSITION.

JUDGE INFORMATION IS IN HEAVY BORDERED BOX ON DRIVER'S COPY.

PAYMENTS FOR FINES SHOULD BE SENT TO THE COURT LISTED ON THE DRIVER'S COPY.

DO NOT SEND PAYMENTS TO TX DPS/MCB.

CERTIFICATION OF REPAIRMAN

I CERTIFY THAT THE REQUIRED REPAIRS SHOWN IN THE "OUT OF SERVICE" COLUMN ON THE OTHER SIDE OF THIS CERTIFICATE HAVE BEEN SATISFACTORILY COMPLETED.

SIGNATURE OF REPAIRMAN:

NAME OF SHOP (GARAGE):

REPAIR WORK COMPLETED

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MOTOR CARRIER CERTIFICATION OF ACTION TAKEN

I CERTIFY THAT ALL VIOLATIONS NOTED UPON THIS REPORT HAVE BEEN CORRECTED AND ACTION HAS BEEN TAKEN TO ASSURE COMPLIANCE WITH THE MOTOR CARRIER SAFETY REGULATIONS INSOFAR AS THEY ARE APPLICABLE TO MOTOR CARRIERS AND DRIVERS.

SIGNATURE OF CARRIER OFFICIAL:

TITLE:

DATE:

5-7-07

Lobban Chayda

HSE Manage

ATTENTION DRIVER:

This report must be furnished to the motor carrier whose name appears on this report.

ATTENTION DRIVER:

TRC Chapter 644, Revised Statutes, requires the Motor Carrier to execute the above certification

and return this report to: MOTOR CARRIER BUREAU

TEXAS DEPARTMENT OF PUBLIC SAFETY

PO BOX 4087

AUSTIN TX 78773-0521

IMPORTANT MESSAGES

Any enforcement actions taken against you and any subsequent court actions are intended to secure compliance with the traffic laws and all other users of the highways. Failure to comply with your written promise to appear in court as made on this citation will constitute a separate offense with which you may be charged and result in warrants being issued for your arrest. Failure to appear in court or failure to satisfy a judgement ordering payment of a fine and cost in the manner ordered by the court may result in the denial of renewal of your driver's license.

"A second or subsequent conviction of failure to maintain financial responsibility will result in the suspension of your driver license and motor vehicle registration unless you file and maintain proof of financial responsibility with the Department of Public Safety for two (2) years from the date of conviction. The Department may waive the requirements to file proof of financial responsibility if you file satisfactory evidence with the Department showing that at the time this citation was issued the vehicle was covered by a liability insurance policy or that you were otherwise exempt from the requirements to provide evidence of financial responsibility.

You may be able to require that this charge be dismissed by successfully completing a driving safety course or a motorcycle operator training course. You will lose that right if, on or before your appearance date, you do not provide the court with notice of your request to take the course. This article does not apply to an offense committed by a person who holds a commercial driver's license.

"A conviction of an offense under a traffic law of this state or a political subdivision of this state may result in the assessment on your driver's license of a surcharge under the Driver Responsibility Program."

A request for an out-of-service review, regarding operating authority, must be made in writing and forwarded to the manager of the Motor Carrier Bureau. If requested, a review will be scheduled and conducted by the manager of the Motor Carrier Bureau or the director's designee within 10 days of the issuance of the out-of-service order. A request for review should be addressed to the Texas Department of Public Safety, Motor Carrier Bureau, P.O. Box 4087, Austin, TX 78773-0521 or may be sent by facsimile transmission to (512) 424-5712 or via electronic mail at <u>MotorCarrierBureau@txdps.state.tx.us.</u> The Department may conduct the review by telephone conference call.

To obtain a TxDOT Motor Carrier Insurance Certificate or Single State Registration - contact the Texas Department of Transportation at 1-800-299-1700 or visit their website at www.dot.state.tx.us.

To obtain a USDOT Number contact the Federal Motor Carrier Safety Administration at 1-800-832-5660 or visit their website at www.fmcsa.dot.gov/factsfigs/formspubs.htm.

To obtain IFTA information contact the State of Texas Comptrollers Office at 1-800-252-1383 or visit their website at www.window.state.tx.us/taxinfo/fuels/lifta.html.

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5/2/2007 6:18:00AM

ENFORCEMENT

CONTINUATION SHEET

OPERATOR

INSPECTION #

LAST NAME

<u>JOE</u>

A MI

TO DRIVER: This report must be furnished to the motor carrier whose name appears on this report. NOTE TO MOTOR CARRIER: TRC Chapter quires the Motor Carrier to execute the certification on the reverse side and return this report to Texas Department of Public Safety, Motor Carrier Section, PO Box 4087, Austin, Texas 78773-0001 within fifteen (15) days.

VIOL. CITE # Unit OOS OOS POST No. Y/N DISP ACC 393.11 2

VIOLATIONS DISCOVERED

DEFECTIVE ID LAMP (FRONT/REAR) - RR

| VEHICLE/DRIVER OUT OF SE | RVICE NOTICE | |
|--|---|--|
| ervice" the vehicle/s with defects followed by "YES" in the Out of Service mn of this report. No person shall remove the out of service stickers ied to these vehicles or operate such vehicles until the out of service cts have been repaired and the vehicles have been restored to safe operating ition, or proper operating authority has been obtained. TINUATION SHEET: X TROOPER COMMENTS: VIN DESIGNATION | DRIVER Pursuant to authority contained in TRC Chapter 644 I hereby notify and declare the driver named on this report Out of Service. No motor carrier shall permit or require driver to drive or operate any motor vehicle until | OOS DISPOSITIONS A. Repaired at Scene / Obtained Oper. Autn. B. Towed/Escorted to Repair Sarvice D. Other D. Unknown N. Driver OOS |
| • | COPY RECEIVED BY | Log Book Exemption |
| ED BY: ID/REGION/DISTRICT/AREA TIME COMPLETS OBBY LYNN 04075 2 A 06 6:28AM BY: | EU REPORT PREPARED BY: PERRY, BOBBY LY: REFERRAL ID BRAKES INSPECTED BY: | , and |



Equipment and Facility Work Order

| Date 5/4/07 | | | | | | | |
|---|---|--------------------|--|--|--|--|--|
| Equipment Number or Description | CES Customer and Job (for customer damage only) | | | | | | |
| 254 | | | | | | | |
| Equipment Type or Area | | | | | | | |
| Description of Job Lights not working | | | | | | | |
| Description of Work Preformed | Cost of Parts | Labor Hours Worked | | | | | |
| repaired wiving intrailer | | 1.0 Javier | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| Shop Supplie | s 2€ = | | | | | | |
| Total Cost for Parts \$ \(\frac{20^{\infty}}{20^{\infty}} \) Total Labor (hours x \$55.00) \$ \(\frac{55^{\infty}}{25^{\infty}} \) Total Cost to Complete Work \$ \(\frac{75^{\infty}}{25^{\infty}} \) | | | | | | | |

| Two. pEQAPCO1 | TXDPS COMMERCIAL VEHICLE ENFORCE | CEMENT CP#: 015 | 1818 - |
|--|--|---|--|
| ☐ ARRES TK ☐ 9 - 15 PASS. FOR HIRE ☐ COM. VEH. ☐ 16 PASS. FOR HIRE ☐ ACCI ENT ☐ 16 PASS. NOT FOR HIRE | CONSTRUC | tion zone □fixed ☑road | |
| ☐ CDL ☐ SCHEDULE ☐ CHARTER | ☐ INTRASTATE ☐ OCCU | _ | □ SW □ TE |
| DATE: 05/02/2007 TIME: | 5:18 AM COUNTY: POLK HW | Y: (2) US-0059 IN POLK CO. | (406-44 M.P.#: 428 |
| LESSEE/MC: | | usbc | T#: 0869392 |
| ADD/CITY/ST/ZIP: | | ICC | • |
| OWNER: C E S ENVIROMENTAL SERVICES ADD/CITY/ST/ZIP: 4904 GRIGGS RD (3901 TRA | TIMORIUM) HOUSTON TY 77013 | OCKT NORS | |
| CPERATOR: JOE A GONZALES | RACE/SEX: HM | (b) (d) | E#: 7136761460 CARD: 09 10 07 |
| ADD/CITY/ST/ZIP: (b) (4) | | DL #: (b) (4) ST: | • |
| VEH SEARCH: YES MO REASON FOR | STOP: WARN CITATION INS | PECTION CONTRABAND LOCATE | D: TYES NO |
| TYPE OF SEARCH: CONSENT DPC INC. TO | ARREST [] INVENTORY TYPE OF CONTRAB | and: | CURRENCY DOTHER |
| | UNIT TYPE MAKE: L. CO# | | |
| V Ge a. De | 1 TT PTRB 289 2 ST OTHR 254 | TX SEREMENTAL | |
| X | | | |
| SIGNATURE: | | | |
| I HEREBY PROMISE TO APPEAR AT THE TIME AND PLACE DESIGNATED IN THIS NOTICE. (THIS IS |) | | |
| NOT A PLEA OF GUILTY) | x 00 00 | | • |
| ☑ COPY RECEIVED BY | GROSS WEIGHT: | GROUP WEIGHT: | |
| YOU ARE HEREBY NOTIFIED TO APPEAR | | LOAD DISP: | |
| JUDGE: CCURT: | PCT./PLACE: | PERMIT #: | |
| PHONE: ON/BEFORE | AT | | /WR #I |
| ADDRESS: | | | /WR #2 |
| SEAL #'S REMOVED: DEPT. SEAL #: INS | TALLED CVSA DECAL-TT CVSA DE | CCAL-ST CVSA DECAL-ST | |
| SHIPPING #: NONE | CONSIGNOR: NA | CONSIGNEE: NA | |
| COMMODITY: EMPTY | ORIGIN: HOUSTON | TX DESTINATION; SHREVE | PORT LA |
| HM CATEGORY CODE RQ? HW | = ' | ALLEG | SED SPEED |
| ΝĀ | R AV 1 DV 2 DV 2 DV 2 | 4 AX 5 AX 6 AX 7 AX 8 | LIMIT |
| | SPEC. TANK IN 1100 2 100 100 100 100 100 100 100 100 | A A SINA BLAN TIAN BRADAR | CAJI. |
| TICKET VTÖL, CITE # Unit OOS OOS POST | | ONS DISCOVERED | |
| No. Y/N DISP ACC | DRIVER: PLEASE COMELY WITH DIRECTIONS | | |
| 1 | | | |
| 393.11 2 DEFEC | TIVE LICENSE PLATE LAMP (#) - | | |
| 393.11 2 INOPE | RABLE TAIL LAMP - LR | | |
| 393.11 2 DEFEC | TIVE ID LAMP (FRONT/REAR) - LR | • | |
| , 393.11 2 DEFEC | TIVE ID LAMP (FRONT/REAR) - CR | | ļ |
| | | | |
| VERICLE Pursuant to authority contained in TRC of | VEHICLE/DRIVER OUT OF SERVICE NOTI | | OOS Dispositions |
| column of this report. No person shall remove th | e out of service stickers declare t | he driver named on this report | Obtained Oper, Auth. |
| applied to these vehicles or operate such vehicle defects have been repaired and the vehicles have condition, or proper operating authority has been | been restored to safe operating permit or | rvice. No motor carrier shall require driver to drive or ny motor vehicle until | B. Towed/Escorted to Repair Service D. Other |
| SEE CONTINUATION SHEET X TROOPER COMMENTS: | Special Sharake a | ny mason rantone Withha | D. Unknown N. Otiver DOS |
| TEST Y VIN (A) | X 4 ° | . De | į |
| | X *** | • | Log Book Exemption |
| The coding | and the second s | RECEIVED BY | - |
| | /DISTRICT/AREA FIME COMPLETED REPORT PR 75 2 A 06 6:28AM REFERRAL | | เมน |
| CHARGES FILED BY: | BRAKES I | KSPECTED BY: | |

| | TX07300APT01 | TXDPS COMME | ERCIAL VEHICL | E ENFORCEM | ENT CD# | . 0151 | 212 | LEVEL |
|----|---|--------------------------------------|------------------------|--|--|------------------------------|-----------------------|-------------------------------|
| 1 | ARREST TKT 9 ~ 15 PASS. | FOR HIRE | • • | | CL II | . 0151 | 0 + 0 | 2 |
| ı | ☐ COM. VEH. ☐ 16 PASS. FOR ☐ ACCIDENT ☐ 16 PASS. NOT | | ☑ INTERSTATE | CONSTRUCTION | - | _ | DE [| ALCH DS |
| | = | _ | ☐ INTRASTATE | re2 | | LE SE 2A501 | | SW TE |
| | DATE: 04/18/2007 TIME | : 8:37 AM COUNTY: | CHAMBERS | HWY: | (1) IH-0010 | IN CHAMBERS CO | . (7 5 H | |
| ١ | LESSEE/MC: C E S ENVIROMENTAL SE | RVICES | · | <u>.</u> | · · · | USDOT | : 080 | 69392 |
| ١ | ADD/CITY/ST/ZIP: 4904 GRIGGS RD | (3901 TRATLMOBILE) HOUSTO | ON TX 77013 | · | | ICC/MC | :#: 400 | 0234 |
| Į | OWNER: C E S ENVIROMENTAL SERVI | CES | | | | TXDOT# | 005 | 5516524C |
| | ADD/CITY/ST/ZIP: 4904 GRIGGS RD | (3901 TRAILMOBILE) ROUSTO | ON TK 77013 | <u>-</u> | | PHONE | 71: | 36761460 |
| 1 | OPERATOR: PETER JR SEMIEN | | RACE/S | SEX: <u>EM</u> DO | _{DB} : (b) (4) | MED CA | RD: 10- | -08 |
| | ADD/CITY/ST/ZIP: (b) (4) | <u> </u> | | DL # | (b) (4) | ST: <u>TX</u> | DL | CLASS: A |
| ١ | VEH SEARCH: 🔲 YES 🗹 NO | REASON FOR STOP: WARN | CITATION | INSPECT | ON CONTR | ABAND LOCATED: | YES | s <u>□</u> NO |
| ١ | TYPE OF SEARCH: CONSENT PC | ☐ INC. TO ARREST ☐ INVE | NTORY TYPE | OF CONTRABAND: | DRUGS | □weapons □c | URRENCY | OTHER |
| ١ | | | MAKE (| The second secon | | 1 | | |
| İ | Teta Seminos | 1 TT 2 ST | | 283 2815 | TX ME | ALL BUILD THE STREET OF FRAN | | (110 % B1 170K 17 W |
| 1 | X | i, . | 1 | | | | | |
| - | SIGNATURE: | • | | | | | | |
| | ☐ I HEREBY PROMISE TO APPEAR AT T | HE TIME AND | | | | | | |
| ł | PLACE DESIGNATED IN THIS NOTICE NOT A PLEA OF GUILTY) | . (THIS IS | 11 - 00/ | 252001 - | 00 (30 | 2001 | | |
| ١ | | GROSS WEIGH | 0)00 (: | • | • | - | | |
| ŀ | ☑ COBA MECRIAED BA | GRO22 WEIGH | 1. | <u> </u> | GROUP WEIGH | | | <u> </u> |
| ŀ | YOU ARE HEREBY NOTIFIED TO APPEAR | . 70 | | | OAD DISP: | | | |
| Ì | JUDGE: RANDALL VANDEVENTER COURT | • | PCT./PLAC | | CRMIT #: | | | |
| ١ | | EFORE 16-May-2007 | ĄТ | L-,- | WT #1 800 | | VR #1 | |
| L | ADDRESS: P. O. BOX 971 ANAHUAC TX EAL #'S REMOVED: DEPT. S. | | CVSA DECAL-TT | <u></u> | WT #2 0 | | VR #2 | |
| 10 | EAL S REMOVED: DEFI. 3. | AG #; INSTRUMED | CVSA DECAL-11 | CVBA DECAL | -51 CVBA I | | } | |
| | 2167190 | | CES | | | NEWBARK | INDUST | RTAT. |
| - | SHIPPING #: | CONSIGNOR: | VIOVE OFFICE | | CONSIGNEE | i: | | |
| | COMMODITY: WASTWATER | ORIGIN: | HOUSTON | | DESTINATI | ON: WINNIE | | TX |
| l | HM CATEGORY COL | | ? R | | | | D SPEED | |
| 1 | , NA | SPEC. TANK | AX 1 AX 2 | AX 3 AX 4 A | x 5 Ax 6 Ax | 7 AX 8 | | - |
| ļ | | BEEC. TANK | L | | | RADAR | CELL - | } |
| Ĭ | ICKET VIOL. CITE # Unit OOS OOS | POST | <u> </u> | VIOLATIONS I | DISCOVERED | | | <u> </u> |
| _ | No. Y/N DISE | ACC DRIVER:PLEAS | SE COMPLY WITH | DIRECTIONS ON | BACK SIDE O | F THIS FORM | | |
| | Yes 1 | OVER 34,000 LBS. | TANDEM AXLE | - 35300, 340 | 00, 1300 | * . | | |
| | | | _ | | | | | |
| Ì | | \$ 200 - | fine. | | | | | |
| l | | 7 200 | ,,,, | | | | | |
| l | | | + | | · · | • | | |
| | | | | | | | | |
| Γ | | VEHICLE/DRIVE | R OUT OF SER | VICE NOTICE | | | | |
| - | VEHICLE Pursuant to authority contain | ed in TRC Chapter 644 I hereb | v declare "Out ! | DRIVER Pursua | nt to authorit | y contained in | OOS DISP | |
| İ | of Service" the vehicle/s with defect column of this report. No person sha applied to these vehicles or operate | ll remove the out of service a | stickers ; | declare the d | 44 I hereby no river named on e. No motor ca | this report | Obtained | red at Scene / Oper, Auth. |
| l | defects have been repaired and the ve condition, or proper operating author | hicles have been restored to a | safe operating | permit or req | uire driver to otor vehicle u | drive or | Repair So D. Other | |
| L | EE CONTINUATION SHEET TROOPER | COMMENTS: | | ~,~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ | | | U. Unknow | wn |
| T | -Y, VI <mark>N (())</mark> | | | PARO | ~~ | | | |
| | | | | X IN Sep | eny) | | □1.00 P | ook Francisco |
| _ | | | | COPY RECE | | | Bod Br | ook Exemption |
| J | NSPECTED BY: IDDICK, ALAN S | ID/REGION/DISTRICT/AREA 04584 2 A 04 | TIME COMPLETED 9:28AM | REPORT PREPA REFERRAL ID | | DICK, ALAN S | | |
| | HARGES FILED BY: RIDDICK, ALAN : | | | BRAKES INSPE | ! | | | |
| _ | | | | | | | ! | |

ANY ENTRIES IN THE VIOLATIONS' SECTION OF DRIVER'S COPY, WHERE THERE IS "YES" IN THE TICKET BOX, INDICATES CHARGES FILED AGAINST THE DRIVER. THIS WILL REQUIRE CONTACTING THE JUDGE FOR APPROPRIATE DISPOSITION.

JUDGE INFORMATION IS IN HEAVY BORDERED BOX ON DRIVER'S COPY.

PAYMENTS FOR FINES SHOULD BE SENT TO THE COURT LISTED ON THE DRIVER'S COPY. DO NOT SEND PAYMENTS TO TX DPS/MCB.

| CERTIFICATION OF REPAIRMAN | | | | | | | | | |
|--|---|-----------------------|--|--|--|--|--|--|--|
| I CERTIFY THAT THE REQUIRED REPAIRS SHOWN IN THE "OUT OF SERVICE" COLUMN ON THE OTHER SIDE | | | | | | | | | |
| OF THIS CERTIFICATE HAVE BEEN : | OF THIS CERTIFICATE HAVE BEEN SATISFACTORILY COMPLETED. | | | | | | | | |
| SIGNATURE OF REPAIRMAN: | NAME OF SHOP (GARAGE): | REPAIR WORK COMPLETED | | | | | | | |
| DATE: TIME: | | | | | | | | | |
| | | | | | | | | | |

MOTOR CARRIER CERTIFICATION OF ACTION TAKEN

I CERTIFY THAT ALL VIOLATIONS NOTED UPON THIS REPORT HAVE BEEN CORRECTED AND ACTION HAS BEEN TAKEN TO ASSURE COMPLIANCE WITH THE MOTOR CARRIER SAFETY REGULATIONS INSOFAR AS THEY ARE APPLICABLE TO MOTOR CARRIERS AND DRIVERS.

| SIGNATURE OF CARRIER OFFICIAL: |
|--------------------------------|
| SIGNATURE OF CARRIER OFFICIAL: |
| I have ful thanks |
| Novel - |

HSE Manager

DATE: 4-23-07

ATTENTION DRIVER:

This report must be furnished to the motor carrier whose name appears on this report.

ATTENTION DRIVER:

TRC Chapter 644, Revised Statutes, requires the Motor Carrier to execute the above certification

and return this report to:

MOTOR CARRIER BUREAU

TEXAS DEPARTMENT OF PUBLIC SAFETY PO BOX 4087

AUSTIN TX 78773-0521

IMPORTANT MESSAGES

Any enforcement actions taken against you and any subsequent court actions are intended to secure compliance with the traffic laws and all other users of the highways. Failure to comply with your written promise to appear in court as made on this citation will constitute a separate offense with which you may be charged and result in warrants being issued for your arrest. Failure to appear in court or failure to satisfy a judgement ordering payment of a fine and cost in the manner ordered by the court may result in the denial of renewal of your driver's license.

"A second or subsequent conviction of failure to maintain financial responsibility will result in the suspension of your driver license and motor vehicle registration unless you file and maintain proof of financial responsibility with the Department of Public Safety for two (2) years from the date of conviction. The Department may waive the requirements to file proof of financial responsibility if you file satisfactory evidence with the Department showing that at the time this citation was issued the vehicle was covered by a liability insurance policy or that you were otherwise exempt from the requirements to provide evidence of financial responsibility,

You may be able to require that this charge be dismissed by successfully completing a driving safety course or a motorcycle operator training course. You will lose that right if, on or before your appearance date, you do not provide the court with notice of your request to take the course. This article does not apply to an offense committed by a person who holds a commercial driver's license.

A request for an out-of-service review, regarding operating authority, must be made in writing and forwarded to the manager of the Motor Carrier Bureau, If requested, a review will be scheduled and conducted by the manager of the Motor Carrier Bureau or the director's designee within 10 days of the issuance of the out-of-service order. A request for review should be addressed to the Texas Department of Public Safety, Motor Carrier Bureau, P.O. Box 4087, Austin, TX 78773-0521 or may be sent by facsimile transmission to (512) 424-5712 or via electronic mail at Motor Carrier Bureau@txdps.state.tx.us. The Department may conduct the review by telephone conference call.

To obtain a TxDOT Motor Carrier Insurance Certificate or Single State Registration - contact the Texas Department of Transportation at 1-800-299-1700 or visit their website at www.dot.state.tx.us.

To obtain a USDOT Number contact the Federal Motor Carrier Safety Administration at 1-800-832-5660 or visit their website at www.fmcsa.dot.gov/factsfigs/formspubs.htm.

To obtain IFTA information contact the State of Texas Comptrollers Office at 1-800-252-1383 or visit their website at www.window.state.tx.us/taxinfo/fuels/ifta.html.

CES ENVIRONMENTAL SERVICES, INC.

4904 GRIGGS ROAD HOUSTON, TEXAS 77021 (713) 676-1460 BANK OF AMERICA, NA 35-2/1130

30134

5/11/2007

PAY TO THE ORDER OF ...

Randall Vandevente

\$ **200.00

Two Hundred and 00/100********

DOLLARS 🔂 🎬

Randall Vandevente Justice of the Peace P O Box 971 Anahuac, TX 77514

CP # 0151818

10301340

30134

CES ENVIRONMENTAL SERVICES, INC.

Randali Vandevente

Date 5/8/2007

405362

Type

Reference TX07300APT01 Original Amt. 200.00

5/11/2007 Balance Due 200.00

Discount

Payment 200.00 200.00

Check Amount

CES Environmental S CP # 0151818

200.00

DATE 05/15/2007

RANDY VAN DEVENTER
JUSTICE OF THE PEACE, PCT 2
CHAMBERS COUNTY

RECEIPT # 15672

CASE # 129066

MAY 1 6 2007

TIME 10:29

RECEIVED OF: CES ENVIRONMENTAL

COMMENTS:

FOR: SEMIEN, PETER JR

DESCRIPTION: OVER 34,000 TANDEM AXLE: UNDER 5,000

A RIDDICK

AMOUNT DUE \$200.00

AMOUNT PAID \$200.00

BALANCE

\$.00

PAYMENT TYPE K
CHECK NO 30134
COLLECTED BY BF



| TX073M0BAI06 | TXDPS COMMERCIAL VEHICLE ENFORCE | CEMENT CP#: 0151818 | LEVEL |
|---|---|--|--|
| ☐ ARREST TKT ☐ 9 - 15 PASS. FOR HIRE ☐ COM. VEH. ☐ 16 PASS. FOR HIRE ☐ ACCIDENT ☐ 16 PASS. NOT FOR HIRE ☐ CDL ☐ SCHEDULE ☐ CHARTER | SP PROG: | TION ZONE | LCH DS |
| DATE: 05/10/2007 TIME: 10 | :37 AM COUNTY: WALKER HW | Y: (1) IH-0045 IN WALKER CO. (101- M. | ₽.#: 101 |
| LESSEE/MC: | | USDOT#: 0869 | - |
| ADD/CITY/ST/ZIP: | • | ICC/MC#: 4002 | |
| OWNER: C E S ENVIROMENTAL SERVICES | | • | 516524C |
| ADD/CITY/ST/ZIP: 4904 GRIGGS RD (3901 TRAI | RACE/SEX: WM | (b) (4) | 761460 7/2008 |
| ADD/CITY/ST/ZIP: (b) (4) | | | CLASS: A |
| VEH SEARCH: ☐ YES ☑ NO REASON FOR | | PECTION CONTRABAND LOCATED: YES | □ио |
| TYPE OF SEARCH: CONSENT PC INC. TO | | | OTHER |
| X A - Mules | UNIT TYPE MAKE GO# | (b) (4) ST. TX. TX. | |
| I HEREBY PROMISE TO APPEAR AT THE TIME AND PLACE DESIGNATED IN THIS NOTICE. (THIS IS NOT A PLEA OF GUILTY) | | | |
| | X(0)OO(0)OO(0) GROSS WEIGHT: | G GROUP WEIGHT: | n |
| COPY RECEIVED BY | GROSS WEIGHT. | LOAD DISP: | |
| YOU ARE HEREBY NOTIFIED TO APPEAR JUDGE: COURT: | PCT./PLACE: | | |
| PHONE: ON/BEFORE | AT | PERMIT #: RG WT #1 80000 GVWR #1 | |
| ADDRESS: | | RG WT #2 0 GVWR #2 | |
| SEAL #'S REMOVED: DEPT. SEAL #; INST | ALLED CVSA DECAL-TT CVSA DE | ECAL-ST CVSA DECAL-ST | |
| | 5947893 | | |
| SHIPPING #: 002166888 | CONSIGNOR: KMTEX | CONSIGNEE: SVSTECH ENVIRON | MENT |
| COMMODITY: WASTE FLAMMABLE | ORIGIN: PORT ARTHUR | TX DESTINATION: FREDONIA | KS |
| HM CATEGORY CODE RQ? HW | ? PLACARDS REQ? | ALLEGED SPEED | : : |
| BULK 3 C | SPEC. TANK AX 1 AX 2 AX 3 AX 307 L | SPEED LIMIT 4 AX 5 AX 6 AX 7 AX 8 RADAR CAL. | |
| TICKET VIOL. CITE # Unit 000 000 POST No. Y/N DISF ACC | DRIVER:PLEASE COMPLY WITH DIRECTION | ONS DISCOVERED S ON BACK SIDE OF THIS FORM | |
| | | | |
| | | | |
| | VEHICLE/DRIVER OUT OF SERVICE NOT | | |
| VEHICLE Fursuant to authority contained in TRC Cha of Service" the vehicle's with defects followed by column of this report. No person shall remove the applied to these vehicles or operate such vehicles defects have been repaired and the vehicles have been repaired and the vehicles have been condition, or proper operating authority has been SEE CONTINUATION SHEET TROOPER COMMENTS: VIN 10 DRUG TESTING-YES DRIVER: 030-796-4558 TXDOT REQUIRED-NO | out of service stickers declare to out of service stickers until the out of service seen restored to safe operating obtained. | the driver named on this report Obtained (| ed at Scene / Oper. Auth. Escorted to rvice |
| WASTE FLAMMABLE LIQUIDS, NOS, CONTAINS HEXANE, ET | | RECEIVED BY | ck Exemption |
| i · | DISTRICT/AREA TIME COMPLETED REPORT P 1 6 M 02 11:01AM REFERRA | REPARED BY: BOYD, PERRY | |
| פונתתים דבבהט סו: | SMAKES I | NSPECTED BY: | ŀ |

ANY ENTRIES IN THE VIOLATIONS' SECTION OF DRIVER'S COPY, WHERE THERE IS "YES" IN THE TICKET BOX, INDICATES CHARGES FILED AGAINST THE DRIVER. THIS WILL REQUIRE CONTACTING THE JUDGE FOR APPROPRIATE DISPOSITION.

JUDGE INFORMATION IS IN HEAVY BORDERED BOX ON DRIVER'S COPY.

PAYMENTS FOR FINES SHOULD BE SENT TO THE COURT LISTED ON THE DRIVER'S COPY.

DO NOT SEND PAYMENTS TO TX DPS/MCB.

| f | CERTIFICATION OF REPAIRMA PAIRS SHOWN IN THE "OUT OF SER' SATISFACTORILY COMPLETED. | | N THE OTHER SIDE | | |
|--|---|----------------|------------------|--|--|
| SIGNATURE OF REPAIRMAN: | NAME OF SHOP (GARAGE): | REPAIR WO | RK COMPLETED | | |
| DATE: TIME: | | | | | |
| | | | | | |
| I CERTIFY THAT ALL VIOLATIONS N | RRIER CERTIFICATION OF ACT | EN CORRECTED | | | |
| BEEN TAKEN TO ASSURE COMPLI. THEY ARE APPLICABLE TO MOTOR | | SAFEIT MEGULAI | IONS INSOFAR AS | | |

ATTENTION DRIVER:

This report must be furnished to the motor carrier whose name appears on this report.

ATTENTION DRIVER:

TRC Chapter 644, Revised Statutes, requires the Motor Carrier to execute the above certification

and return this report to: MOTOR CARRIER BUREAU

TEXAS DEPARTMENT OF PUBLIC SAFETY

PO BOX 4087 AUSTIN TX 78773-0521

IMPORTANT MESSAGES

Any enforcement actions taken against you and any subsequent court actions are intended to secure compliance with the traffic laws and all other users of the highways. Failure to comply with your written promise to appear in court as made on this citation will constitute a separate offense with which you may be charged and result in warrants being issued for your arrest. Failure to appear in court or failure to satisfy a judgement ordering payment of a fine and cost in the manner ordered by the court may result in the denial of renewal of your driver's license.

"A second or subsequent conviction of failure to maintain financial responsibility will result in the suspension of your driver license and motor vehicle registration unless you file and maintain proof of financial responsibility with the Department of Public Safety for two (2) years from the date of conviction. The Department may waive the requirements to file proof of financial responsibility if you file satisfactory evidence with the Department showing that at the time this citation was issued the vehicle was covered by a liability insurance policy or that you were otherwise exempt from the requirements to provide evidence of financial responsibility.

You may be able to require that this charge be dismissed by successfully completing a driving safety course or a motorcycle operator training course. You will lose that right if, on or before your appearance date, you do not provide the court with notice of your request to take the course. This article does not apply to an offense committed by a person who holds a commercial driver's license.

"A conviction of an offense under a traffic law of this state or a political subdivision of this state may result in the assessment on your driver's license of a surcharge under the Driver Responsibility Program."

A request for an out-of-service review, regarding operating authority, must be made in writing and forwarded to the manager of the Motor Carrier Bureau. If requested, a review will be scheduled and conducted by the manager of the Motor Carrier Bureau or the director's designee within 10 days of the issuance of the out-of-service order. A request for review should be addressed to the Texas Department of Public Safety, Motor Carrier Bureau, P.O. Box 4087, Austin, TX 78773-0521 or may be sent by facsimile transmission to (512) 424-5712 or via electronic mail at MotorCarrierBureau@txdps.state.tx.us. The Department may conduct the review by telephone conference call.

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To obtain a USDOT Number contact the Federal Motor Carrier Safety Administration at 1-800-832-5660 or visit their website at www.fmcsa.dot.gov/factsfigs/formspubs.htm.

To obtain IFTA information contact the State of Texas Comptrollers Office at 1-800-252-1383 or visit their website at

DS TE

| TX073R0ABS05 | TXDPS COMMERCI L VEHICLE | ENFORCEMENT - | LEVE |
|--|---|---|------------------------------------|
| ☑ ARREST TKT ☐ 9 - 15 PASS. FOR HIRE | | ⊸ C₽#:0 | 151818 |
| COM. VEH. 16 PASS. FOR HIRE | NING DORAGE | CONSTRUCTION ZOND | ☐ROADSIDE |
| ☐ ACCIDENT ☐ 16 PASS, NOT FOR HIRE | - NINDACTANT | YES M NO SCALE | ☐ ALCH ☐ DS |
| | L | OCCUPIED HOUSE 3A3 | SW 1 70 |
| • | 7:36PM COUNTY: VIC TORIA | HWY: (2) US-0059 IN VICT | ORTA CO. (6: M.P.#: 622 |
| LESSEE/MC: | | | USDOT#: 0869392 |
| ADD/CITY/ST/ZIP: | | | ICC/MC#: 400234 |
| OWNER: C E S ENVIROMENTAL SERVICES | 77013 | | TXDOT#: 005516524C |
| ADD/CITY/ST/ZIP: 4904 GRIGGS RD (3901 TRAI: | RACE/SEX | (5) (4) | PHONE#: 7136761460 |
| OPERATOR: GUADALUPE CAMPOS | MCS/ SEA | 141 DOB: | MED CARD: 2-09 |
| ADD/CITY/ST/ZIP: L(0) (4) | CIEDARYOU | DL #: (b) (4) | ST: TX DL CLASS: A |
| VEH SEARCH: YES NO REASON FOR | | ☐INSPECTION CONTRABAND L | OCATED: TYES TO |
| TYPE OF SEARCH: CONSENT PC INC. TO | | CONTRABAND: DRUGS DWEAPO | NS CURRENCY COTHER |
| | D B 200 | 7 (a) (4) ST | |
| | 1 TT PTRB 288 | | |
| X cutof agr | | | |
| SIGNATURE: | | 111 am (#)# | WE BEING |
| | | | |
| I HEREBY PROMISE TO APPEAR AT THE TIME AND PLACE DESIGNATED IN THIS NOTICE. (THIS IS | | | |
| NOT A PLEA OF GUILTY) | x 0000 | | |
| COPY RECEIVED BY | GROSS WEIGHT: | GROUP WEIGHT: | |
| YOU ARE HEREBY NOTIFIED TO APPEAR | | LOAD DISP: | |
| JUDGE: HENRY A WELFEL COURT: JP |) PCT./PLACE: 4 | PERMIT #: | |
| PHONE: (361) 573~5073 ON/BEFORE 06-2 | fun-2007 AT 10 | 0:00AM RG WT #1 80000 | GVWR #1 |
| ADDRESS: 104 TEAKWOOD STE #3 VICTORIA TX 7790 | .acrae | RG WT #2 0 | GVWR #2 |
| SEAL #'S REMOVED: DEPT. SEAL #; TNSTA | ALLED CVSA DECAL-TT C | /SA DECAL-ST CVSA DECAL-ST | |
| | | | |
| SHIPPING #: 41342 | CONSIGNOR: TRANSMONTAINGE F | RODUCT CONSIGNEE: CES | ENVIRONMENTAL |
| COMMODITY: FLAMMABLE LIQUIDS | ORIGIN: BROWNSVILLE | TX | ICES |
| HM CATEGORY CODE RQ? HW | <u> </u> | T | TX |
| BULK 3 | R R | | EGED SPEED |
| | SPEC. TANK AX 1 AX 2 AX 3 | AA 4 AX 5 AX 6 AX 7 AX 8 | CED LIMIT |
| | 307 L | | AR CAL. |
| TICKET VIOL. CITE # Unit OOS Y/ OOS POST | VIOI | ATIONS DISCOVERED | |
| No. N DISP ACC FAIL TO THE PROPERTY OF THE PRO | DRIVER: PLEASE COMPLY WITH DIRECTOR PERFORM REQUIRED PERFORM REQUIRED | FIONS ON BACK SIDE OF AVER | |
| [] | | | |
| | ED CMV INSPECTION CERTIFICATE | | 7 |
| 391.11(b)(5) D Yes N NO TAN | K VEHICLE ENDORSEMENT (N) - HAZ-MA | T ENDORSEMENT ONLY | |
| 172.602(b) (2 1 EMERGE | NCY RESPONSE INFORMATION NOT ACCES | SIBLE - | |
|] ; ; | | | |
| 177.817(e) 1 SHIPPI | NG PAPER NOT ACCESSIBLE | | |
| | /EHICLE/DRIVER OUT OF SERVICE N | OTICE | |
| VPHICLE Pursuant to authorize contained in TRC Cha | Tox 644 T horoby doclare "Out TORIVE | R Pursuant to | |
| column of this report. No person shall remove the | out of annuise stickers declar | e the driver mereby notify and | A. Repaired at Scane |
| applied to these vehicles or operate such vehicles defects have been repaired and the vehicles have be | on restored to cofe operating Dermit | Or recuire du motor carrier shall | B. Towed/Escorted to |
| condition, or proper operating authority has been see CONTINUATION SHEET X TROOPER COMMENTS: | | e any motor vehicle until NS PROPER CDL ENDORSEMENT | Repair Service D. Other U. Unknown |
| FLAMMABLE LIQUIDS, N.O.S., UN 1268, PG II, DRIV | ER HAS HAZ-MAT ENDORSEMENT | | N. Driver oos |
| ONLY, NEED TANK ENDORSEMENT ALSO, TEST DATES V LOADED 5-18-07, LAST DUTY STATUS IS IN BROWNSVI | | Helm | |
| | COP | Y RECEIVED BY | Log Book Exemption |
| INSPECTED BY: ID/REGION/I | DISTRICT/AREA TIME COMPLETED REPORT | PREPARED BY: LONGORTA FURNIS | |
| · · · · · · · · · · · · · · · · · · · | 3 A 03 8:25PM REFERE | RAL ID | RUO R |
| CHARGES FILED BY: LONGORIA, EVERARDO R 06 | .91 3A03 BRAKES | INSPECTED BY: | |

ANY ENTRIES IN THE VIOLATIONS' SECTION OF DRIVER'S COPY, WHERE THERE IS "YES" IN THE TICKET BOX, INDICATES CHARGES FILED AGAINST THE DRIVER. THIS WILL REQUIRE CONTACTING THE JUDGE FOR APPROPRIATE DISPOSITION.

JUDGE INFORMATION IS IN HEAVY BORDERED BOX ON DRIVER'S COPY.

PAYMENTS FOR FINES SHOULD BE: SENT TO THE COURT LISTED ON THE DRIVER'S COPY.

DO NOT SEIND PAYMENTS TO TX DPS/MCB.

CERTIFICATION OF REPAIRMAN

I CERTIFY THAT THE REQUIRED REPAIRS SHOWN IN THE "OUT OF SERVICE" COLUMN ON THE OTHER SIDE OF THIS CERTIFICATE HAVE BEEN SATISF ACTORILY COMPLETED.

SIGNATURE OF REPAIRMAN:

NAME OF SHOP (GARAGE):

REPAIR WORK COMPLETED

500

CES Show

5-46-07 Sign

MOTOR CARRIEF CERTIFICATION OF ACTION TAKEN

I CERTIFY THAT ALL VIOLATIONS NOTED UPON THIS REPORT HAVE BEEN CORRECTED AND ACTION HAS BEEN TAKEN TO ASSURE COMPLIANCE WITH THE MOTOR CARRIER SAFETY REGULATIONS INSOFAR AS THEY ARE APPLICABLE TO MOTOR CARRIERS AND DRIVERS.

SIGNATURE OF CARRIER OFFICIAL:

TITLE:

DATE:

5-17-07

ATTENTION DRIVER:

This report must be furnished to the motor carrier whose name appears on this report.

ATTENTION DRIVER:

TRC Chapter 644, Revised Statutes, requires the Motor Carrier to execute the above certification

and return this report to: MOTOR CARRIER BUREAU

HSE Manage

TEXAS DEPARTMENT OF PUBLIC SAFETY

PO BOX 4087

AUSTIN TX 78773-0521

IMPORTANT MESSAGES

Any enforcement actions taken against you and any subsequent court actions are intended to secure compliance with the traffic laws and all other users of the highways. Failure to comply with your written promise to appear in court as made on this citation will constitute a separate offense with which you may be charged and result in warrants being issued for your arrest. Failure to appear in court or failure to satisfy a judgement ordering payment of a fine and cost in the manner ordered by the court may result in the denial of renewal of your driver's license.

"A second or subsequent conviction of failure to maintain financial responsibility will result in the suspension of your driver license and motor vehicle registration unless you file and maintain proof of financial responsibility with the Department of Public Safety for two (2) years from the date of conviction. The Department may waive the requirements to file proof of financial responsibility if you file satisfactory evidence with the Department showing that at the time this citation was issued the vehicle was covered by a liability insurance policy or that you were otherwise exempt from the requirements to provide evidence of financial responsibility.

You may be able to require that this charge be dismissed by successfully completing a driving safety course or a motorcycle operator training course. You will lose that right if, on or before your appearance date, you do not provide the court with notice of your request to take the course. This article does not apply to an offense committed by a person who holds a commercial driver's license.

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A request for an out-of-service review, regarding operating authority, must be made in writing and forwarded to the manager of the Motor Carrier Bureau. If requested, a review will be scheduled and conducted by the manager of the Motor Carrier Bureau or the director's designee within 10 days of the issuance of the out-of-service order. A request for review should be addressed to the Texas Department of Public Safety, Motor Carrier Bureau, P.O. Box 4087, Austin, TX 78773-0521 or may be sent by facsimile transmission to (512) 424-5712 or via electronic mail at MotorCarrierBureau@txdps.state.tx.us. The Department may conduct the review by telephone conference call.

To obtain a TxDOT Motor Carrier Insurance Certificate or Single State Registration - contact the Texas Department of Transportation at 1-800-299-1700 or visit their website at www.dot.state.tx.us.

To obtain a USDOT Number contact the Federal Motor Carrier Safety Administration at 1-800-832-5660 or visit their website at www.fmcsa.dot.gov/factsfigs/formspubs.htm.

To obtain IFTA information contact the State of Texas Comptrollers Office at 1-800-252-1383 or visit their website at www.window.state.tx.us/taxinfo/fuels/ifta.html.

| CVE-3.1 (12/03) | | INSPECTION | N # | CP # | DATE | |
|-----------------------|----------------------|--|---|--|---|---------------------------------------|
| | | TX | (073R0ABS05-0 | | 5/15/2007 | 7:36:00PM |
| or Pug | TXDPS COMME | ERCIAL MOTOR CAR | RIER | | | |
| T E X CO | VEHICLE ENFORCEM | FNT | | | | |
| ă X | | OPERATOR OPERATOR | | | | |
| T A | / | | CAMPOS | GUADA | LUPE | |
| PRO-MONT PORT | CONTINUATION | SHEET | LAST NAME | FIRST | NAME MI | |
| 644 requires the Moto | r Carrier to execute | furnished to the motor the certification on the exas 78773-0001 with | carrier whose name appe reverse side and return t in fifteen (15) days. | ears on this report. NO his report to Texas Dep | TE TO MOTOR CARR partment of Public Safe | IER: TRC Chapter ty, Motor Carrier |
| | | | VIOLATIONS | | | |
| FICKET VIOL. CITE # | | POST; ACC; | v | IOLATIONS DISCOVER | ED | |

FAIL TO PERFORM REQUIRED PERIODIC TEST ON CARGO TANK - V

DUTY STATUS NOT CURRENT - THIS DATE 7AM

180.407(c)

395.8(f)(1) D

| | VEHICLE/DRIVE | R OUT OF SE | RVICE NOTICE | |
|---|--|-----------------------|--|-----------------------------|
| DVEHICLE Pursuant to authority control of Service" the vehicle/s with defection of this report. No person supplied to these vehicles or operadefects have been repaired and the condition, or proper operating authority. | cts followed by "YES" in the Out hall remove the out of service s e such vehicles until the out of vehicles have been restored to s | stickers f service | DRIVER Pursuant to authority contained TRC Chapter 644 I hereby notify and declare the driver named on this report out of Service. No motor carrier shall permit or require driver to drive or operate any motor vehicle until | t Obtained Oper, Auth. |
| FLAMMABLE LIQUIDS, N.O.S., UN 1260 ONLY, NEED TANK ENDORSEMENT ALSO, | , PG II, DRIVER HAS HAZ-MAT TEST DATES V K EXPIRED 4~07 | , PRODUCT | OBTAINS PROPER COL ENDORSEMENT | U. Unknown N. Driver OOS |
| SEE CONTINUATION SHEET X TROOPS FLAMMABLE LIQUIDS, N.O.S., UN 126 ONLY, NEED TANK ENDORSEMENT ALSO, LOADED 5-18-07, LAST DUTY STATUS | , PG II, DRIVER HAS HAZ-MAT TEST DATES V K EXPIRED 4~07 | , PRODUCT | X By Cyn | |
| FLAMMABLE LIQUIDS, N.O.S., UN 126 CNLY, NEED TANK ENDORSEMENT ALSO, LOADED 5-18-07, LAST DUTY STATUS | , PG II, DRIVER HAS HAZ-MAT TEST DATES V K EXPIRED 4-07 S IN BROWNSVILLE AT 7AM THI | , PRODUCT S DATE | X Staylogu COPY RECEIVED BY | N. Driver OOS |
| FLAMMABLE LIQUIDS, N.O.S., UN 1260 ONLY, NEED TANK ENDORSEMENT ALSO, | , PG II, DRIVER HAS HAZ-MAT TEST DATES V K EXPIRED 4-07 S IN BROWNSVILLE AT 7AM THI | , PRODUCT S DATE | X By Cyn | N. Driver OOS |

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CERTIFICATION OF REPAIRMAN

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SIGNATURE OF REPAIRMAN:

NAME OF SHOP (GARAGE):

REPAIR WORK COMPLETED

2000

Ces Shop

DATE: 5-16-07

TIME: SAM

MOTOR CARRIER CERTIFICATION OF ACTION TAKEN

CERTIFY THAT ALL VIOLATIONS NOTED UPON THIS REPORT HAVE BEEN CORRECTED AND ACTION HAS BEEN TAKEN TO ASSURE COMPLIANCE WITH THE MOTOR CARRIER SAFETY REGULATIONS INSOFAR AS THEY ARE APPLICABLE TO MOTOR CARRIERS AND DRIVERS.

SIGNATURE OF CARRIER OFFICIAL:

TITLE:

and return this report to:

DATE:

Robband Thange

HSE Manager

5-17-07

ATTENTION DRIVER:

This report must be furnished to the motor carrier whose name appears on this report.

ATTENTION DRIVER:

TRC Chapter 644, Revised Statutes, requires the Motor Carrier to execute the above certification

MOTOR CARRIER BUREAU

TEXAS DEPARTMENT OF PUBLIC SAFETY

PO BOX 4087

AUSTIN TX 78773-0521

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"A second or subsequent conviction of failure to maintain financial responsibility will result in the suspension of your driver license and motor vehicle registration unless you file and maintain proof of financial responsibility with the Department of Public Safety for two (2) years from the date of conviction. The Department may waive the requirements to file proof of financial responsibility if you file satisfactory evidence with the Department showing that at the time this citation was issued the vehicle was covered by a liability insurance policy or that you were otherwise exempt from the requirements to provide evidence of financial responsibility.

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To obtain IFTA information contact the State of Texas Comptrollers Office at 1-800-252-1383 or visit their website at www.window.state.tx.us/taxinfo/fuels/ifta.html.

287





Equipment and Facility Work Order

| Date 5-18-67 | | | |
|---|-----|---------------------------------------|--------------------|
| Equipment Number or Description | С | ES Customer and damage | |
| TRK # 287 | 130 | _ | |
| Equipment Type or Area | | DoT | |
| Description of Job | | | |
| Description of Work Preformed | | Cost of Parts | Labor Hours Worked |
| Complete Not Inspection | | 60°2 | 1.0 |
| | - | · · · · · · · · · · · · · · · · · · · | |
| | | | |
| | | | |
| | | | |
| | | | |
| Total Cost for Parts \$ 60 = Total Labor (hours x \$55.00) \$ 55 = Total Cost to Complete Work \$ 7/5 = 7/5 | | | |

| ARREST TKT | | | MERCIAL VEHICLE EI | | P#·N1 | 51212 1 |
|--|--|---|--|---|---|--|
| COM. VEE. | ☐ 9 - 15 PASS. FOR HIRE ☐ 16 PASS, FOR HIRE | | | | | Ĺ |
| ACCIDENT | 16 PASS. NOT FOR HIRE | SP PROG: | TMPED CRAME | √STRUCTION ZONE YES ☑ NO | ☐FIXED ☑ RO | ADSIDE ALCH |
| ☑ CDL | ☐ SCHEDULE ☐ CHARTER | | | OCCUPIED | HOUSE | □ SW □ |
| DATE: | 06/06/2007 TIME: 8 | 3:45 AM COUNTY | : CHAMBERS | HWY: (2) SH-0 | 061 IN CHAMBE | RS CO. (41 M.P.#: |
| LESSEE/MC: | | | · · · · · · · · · · · · · · · · · · · | | | SDOT#: 0869392 |
| ADD/CITY/ST/ZIP: | | | | | | CC/MC#: 400234 |
| OWNER: CESE | NVIROMENTAL SERVICES | | | | T | (DOT#: 005516524 |
| ADD/CITY/ST/ZIP: | 4904 GRIGGS RD (3901 TRA | ILMOBILE) HOUS | TON TX 77013 | | PI | HONE#: 713676146 |
| OPERATOR: DERE | K LEONDAS TUCKER | | RACE/SEX: | вм ров: | (4) ME | ED CARD: NONE |
| ADD/CITY/ST/ZIP: | (b) (4) | | | DL# (b) (4 | sı sı | T: TX DL CLASS: |
| VEH SEARCH: 🔲 | YES MO REASON FOR | STOP: 🔲 WAR | N CITATION | INSPECTION | CONTRABAND LOC | ATED: YES 🗖 |
| X SIGNAT | CONSENT PC INC. TO | UNIT TYPE 1 TT 2 ST | | ONTRABAND: DRI | | CURRENCY |
| T PLACE DESIGNAT | SE TO APPEAR AT THE TIME AND ED IN THIS NOTICE. (THIS IS | | | | | |
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| OPY RECEIVED . | | GROSS WEIG | HT: | GROUP I | | |
| | OTIFIED TO APPEAR | | | LOAD DIS | | |
| JUDGE: | COURT: | | PCT./PLACE: | PERMIT # | : ; | * - * |
| PHONE: | ON/BEFORE | 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | AT . | | 80000 | GVWR #1 |
| ADDRESS: | | | | RG WT #2 | Ō | GVWR #2 |
| AL #'S REMOVED: | DEPT. SEAL #; INST | ALLED | CVSA DECAL-TT C | VSA DECAL-ST | VSA DECAL-ST | |
| | | 1.1p | | | | |
| SHIPPING #: 216 | 59211 | CONSIGNOR: | NEWPARK DISPOSA | L WELL CONS | IGNEE: CES | YARD |
| COMMODITY: WAS | STE WATER RESIDUE | ORIGIN: | WINNIE | TX DEST | INATION; HOUS | TON |
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| - | NA. POS OS POST No. Y/N DISP ACC | SPEC. TANI | K AX 1 AX 2 AX L VI | OLATIONS DISCOVE | 5 AX 7 AX 8 R | DAR CAL. |
| 393.20 | NA PUNIT OOS OOS POST No. Y/N DISP ACC DEFEC | SPEC. TANI | K AX 1 AX 2 AX VII ASE COMPLY WITH DIRE LAMP - MISSING 1 | OLATIONS DISCOVE ECTIONS ON BACK S LEFT FRONT | 5 AX 7 AX 8 R | DAR CAL. |
| - | NA. Y/N DISP ACC DEFEC | SPEC. TANI | K AX 1 AX 2 AX VII ASE COMPLY WITH DIRE LAMP - MISSING 1 | OLATIONS DISCOVE | 5 AX 7 AX 8 R | DAR CAL. |
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| yehicle Pursuant to of Service the we column of this regaplied to these defects have been condition, or property of the condition of the condi | NA NO. Y/N DISP ACC 2 DEFECT 2 DEFECT As authority contained in TRC Chelicle/s with defects followed be bort. No person shall remove the repaired and the vehicles are determined and the vehicles have been operating authority has been EET TROOPER COMMENTS: | DRIVER:PLEATIVE CLEARANCE TIVE CLEARANCE | VICASE COMPLY WITH DIRECT COMPLY WITH DIRECT COMPLY WITH DIRECT COMPLY WITH DIRECT COMPLY WITH DIRECT COMPLY COMPL | OLATIONS DISCOVE CCTIONS ON BACK S LEFT FRONT RIGHT FRONT E NOTICE TYEK Pursuant to aut C Chapter 64 I her clare the driver nat t of Service. No mot rmit or require driv erate any motor veh: | fiority Contained by notify and led on this report or carrier shall er to drive or cle until | in OOS DISPOSTIONS A. Repaired at S Obtained Oper. A B. Towed/Escorte Repair Service D. Other U. Unknown N. Driver OOS |
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ANY ENTRIES IN THE VIOLATIONS' SECTION OF DRIVER'S COPY, WHERE THERE IS "YES" IN THE TICKET BOX, INDICATES CHARGES FILED AGAINST THE DRIVER. THIS WILL REQUIRE CONTACTING THE JUDGE FOR APPROPRIATE DISPOSITION.

JUDGE INFORMATION IS IN HEAVY BORDERED BOX ON DRIVER'S COPY.

PAYMENTS FOR FINES SHOULD BE SENT TO THE COURT LISTED ON THE DRIVER'S COPY.

DO NOT SEND PAYMENTS TO TX DPS/MCB.

CERTIFICATION OF REPAIRMAN

I CERTIFY THAT THE REQUIRED REPAIRS SHOWN IN THE "OUT OF SERVICE" COLUMN ON THE OTHER SIDE OF THIS CERTIFICATE HAVE BEEN SATISFACTORILY COMPLETED.

SIGNATURE OF REPAIRMAN:

"wood

NAME OF SHOP (GARAGE):

REPAIR WORK COMPLETED

TIME:

C 155

DATE:

1:30PM

MOTOR CARRIER CERTIFICATION OF ACTION TAKEN

I CERTIFY THAT ALL VIOLATIONS NOTED UPON THIS REPORT HAVE BEEN CORRECTED AND ACTION HAS BEEN TAKEN TO ASSURE COMPLIANCE WITH THE MOTOR CARRIER SAFETY REGULATIONS INSOFAR AS THEY ARE APPLICABLE TO MOTOR CARRIERS AND DRIVERS.

SIGNATURE OF CARRIER OFFICIAL:

TITLE:

DATE:

HSE Manage

6-7-07

ATTENTION DRIVER:

This report must be furnished to the motor carrier whose name appears on this report.

ATTENTION DRIVER:

TRC Chapter 644, Revised Statutes, requires the Motor Carrier to execute the above certification

and return this report to: MOTOR CARRIER BUREAU

TEXAS DEPARTMENT OF PUBLIC SAFETY

PO BOX 4087

AUSTIN TX 78773-0521

IMPORTANT MESSAGES

Any enforcement actions taken against you and any subsequent court actions are intended to secure compliance with the traffic laws and all other users of the highways. Failure to comply with your written promise to appear in court as made on this citation will constitute a separate offense with which you may be charged and result in warrants being issued for your arrest. Failure to appear in court or failure to satisfy a judgement ordering payment of a fine and cost in the manner ordered by the court may result in the denial of renewal of your driver's license.

"A second or subsequent conviction of failure to maintain financial responsibility will result in the suspension of your driver license and motor vehicle registration unless you file and maintain proof of financial responsibility with the Department of Public Safety for two (2) years from the date of conviction. The Department may waive the requirements to file proof of financial responsibility if you file satisfactory evidence with the Department showing that at the time this citation was issued the vehicle was covered by a liability insurance policy or that you were otherwise exempt from the requirements to provide evidence of financial responsibility.

You may be able to require that this charge be dismissed by successfully completing a driving safety course or a motorcycle operator training course. You will lose that right if, on or before your appearance date, you do not provide the court with notice of your request to take the course. This article does not apply to an offense committed by a person who holds a commercial driver's license.

"A conviction of an offense under a traffic law of this state or a political subdivision of this state may result in the assessment on your driver's license of a surcharge under the Driver Responsibility Program."

A request for an out-of-service review, regarding operating authority, must be made in writing and forwarded to the manager of the Motor Carrier Bureau. If requested, a review will be scheduled and conducted by the manager of the Motor Carrier Bureau or the director's designee within 10 days of the issuance of the out-of-service order. A request for review should be addressed to the Texas Department of Public Safety, Motor Carrier Bureau, P.O. Box 4087, Austin, TX 78773-0521 or may be sent by facsimile transmission to (512) 424-5712 or via electronic mail at MotorCarrierBureau@txdps.state.tx.us. The Department may conduct the review by telephone conference call.

To obtain a TxDOT Motor Carrier Insurance Certificate or Single State Registration - contact the Texas Department of Transportation at 1-800-299-1700 or visit their website at www.dot.state.tx.us.

To obtain a USDOT Number contact the Federal Motor Carrier Safety Administration at 1-800-832-5660 or visit their website at www.fmcsa.dot.gov/factsfigs/formspubs.htm.

To obtain IFTA information contact the State of Texas Comptrollers Office at 1-800-252-1383 or visit their website at

| TE | XAS DEPARTMENT OF PUBLIC | SAFETY | 10-10-07 | 2 200 PM |
|------------------|---|------------------------------|-----------------------------------|-----------------------|
| | , LAST | FIRST | N | - C 22 |
| DRIVER NAME | | Rob | at A | " M D |
| VEHICLE MAKE & 7 | THE AVE | STATE | 24. l | STATE |
| PB T | (b) (4) | 317 | (b) (4) | 7> |
| COUNTY | LOCATION & ROUTE | | CONST. ZONE LI YES | ANO MILE MARKER |
| B10201 | ia [M-523. | $\rightarrow \omega$ | WORKERS PRESENT DYES DA | 1010 |
| F | | ONTRABAND YES TYPE OF CONTRA | DRUGS CURRENCY DEAD WEAPONS OTHER | CHARGES YES |
| (IOLATION (1) | Dofective 1 | Mudflap | · | |
| OLATION (2) | | | | |
| ircumstances p | NING ONLY for an infraction of the resent. No penalty will be assessed traffic laws in the future. This doe | ed and no further action | on on your part is nece | |
| T A | This warning is given to you in a thus helping to prevent traffic a citizens will comply with traffic compliance with them. | accidents. The Texas De | epartment of Public Safe | ety believes that goo |
| | | SERVICE 🛰 (| | |



Equipment and Facility Work Order

| Date <u>6/0-06-07</u> | | |
|---|-------------------|---------------------------------|
| Equipment Number or Description | | d Job (for customer ge only) |
| | | |
| Equipment Type or Area | | |
| Description of Job LIGHT MOUNT CRACKE | 18 — | |
| Description of Work Preformed | Cost of Parts | Labor Hours Worked |
| (a 1000 010x) | | Labor Flours VVorked |
| REMOVED OLD LIGHT MOUNT BRA FABICATED CORRECT ANGLE MOUNT 2 AMBER ROUND REFLECTORS— | CHETSE BARRIER | 1,0 |
| 2 AMBER ROUND REFLECTORS - | 7,50 | |
| | | |
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| | | |
| | | |
| Shon Swaning | . 500 | |
| 5んら Sッカルさ Total Cost for Parts \$ <u>/2、5○</u> Total Labor (hours x \$55.00) \$ <u>55</u> ~ | | Cunco |
| Total Cost to Complete Work \$ 67.50 | _ | |

| _T0: | 280_030 | ı | | | | | | | | | | | | | | | | | CVE-3 | (Rev. 2, | /041 |
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| | COM. VEH | Ι. |) | - 15 | | | RE | I | ENF | ORCE | MENT | UNIT | | | C | - π | U | | OTO | • | 1 |
| | ACCIDENT | ! | 122.4 | 6 PASS. | | | RE S | SP PROG: | V | INTER | STATE | | STRUCT | | | EIXE | 1.2 | ROADSI | DE _ | ALCH [| J |
| 9 | CDL | | s | CHEDULE | : 🗀 | CHART | SR | | | INTRA | STATE | | YES OCCUP | | , | SCALE | 3 | | | SW 🗆 | , I TE |
| DATE | 3: | 06/0 | 7/2007 | TIME: | 7 | :40 AM | COUN | TY HARRIS | | AD | DRESS | 10600 | EAST | ev Endr | , | | | DENT. | 7040 | KMAP: 41 | 1.4- |
| i | SEE/MC: | | <u> </u> | | | | - | | | 110 | DREDO | | | 4V T W1 | | | | USDOT# | | 169392 | |
| ADD | /CITY/ST/ | ZIP: | 490 | 4 GRIGO | S RD | (3901 | TRAIL | MOBILE) HOUS! | ron ' | тж 770 | 13 | | | | | | | ICC/MC | | 0234 | |
| OWN | ER: CE | SE | NVIROM | ENTAL S | BERVIC | ES | | | | <u></u> . | | | | | | | | TXDOT# | : 00 | 5516524C | |
| ADD, | /CITY/ST/ | ZIP: | 490 | 4 GRIGO | S RD | (3901 | TRATL | MOBILE) HOUST | NO1 | rx 770 | 13 | | | | | | | PHONE# | : 71 | 3-676-14 | 60 |
| OPE | RATOR: 1 | MATTI | HEW T | AYLOR | | | | | | | RACE/ | SEX: | BM | DOB: | (b |) (4) | - | MED CA | RD: 3 | /2008 | |
| ADD, | CITY/ST/ | ZIP: | (b) | (4) | | | | | | | | | | D.L. | #: [| b) (4) | | | S | TATE: T | |
| VEH | SEARCH: | | YES | ✓ NO | R | EASON | FOR S | TOP: WAR | N | []ci | TATIO | 1 [| INSP | ECTION | 1 (| CONTRAB | AND I | OCATED: | T YI | s []No | 0 |
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| | | DIS | TALL, | NOS,3, | | | HW? | PLACARDS RE |] 2? | 1 1/4 | 1 5/8 | 1 1/2 | 1 1/2 | 1 1/2 | \ <u></u> | | | ALLEGE | SPEED | , l | |
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| TICKET | VIOL. CI | TE # | UNIT | oos | oos | POST | | | J | .l | VIOL | L ATION | S DISC | OVERI | ED | <u> </u> | | <u> </u> | | MUNICI | PAL |
| · | 202 02 | | NO. | Y/N | DISP | ACC | ******* | DRIVER: PLEA | | | WITH | DIREC | TIONS | ON B. | ACK S | | THIS | FORM | | · · | |
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| col | umn of thi | s rep | ort. N | No perso | n shall | remove | the o | out of service until the out of | stic | kers | ~ | decla | are the | drive | r name | y notify d on thi r carrie | is rep | ort | Obtaine | red at Sce 1 Oper. Au /Escorted | th. |
| def | | been | repaire | ed and t | he vehi | cles ha | ive bee | en restored to | | | ing | permi | t or r | equire | drive | r to dri le until | ive or | | Repair D. Othe | Service | 10 |
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| D/A=YE | | | <u></u> | | | T | ROOPE | R COMMENTS | | | | | | | | | | - <u></u> - | | | |
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| INSPEC | TED BY: | | | | 1 | | | ISTRICT/AREA | TIM | | | | | | BY: | 094 | 994 | VECERA | , BRYO | N | |
| | | | BRYON | | | 0 | 94994 | 1 2 9 V | | 8:30 | AM | | ERRAL | | | <u> </u> | | . <u>. </u> | | | |
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ANY ENTRIES IN THE VIOLATIONS' SECTION OF DRIVER'S COPY INDICATES CHARGES FILED AGAINST THE DRIVER. THIS WILL REQUIRE CONTACTING THE JUDGE FOR APPROPRIATE DISPOSITION. (JUDGE INFORMATION IN HEAVY BORDERED BOX ON DRIVER'S COPY.)

ATTENTION DRIVER: This report must be furnished to the motor carrier whose name appears on this report.

ATTENTION DRIVER: TRC Chapter 644, Revised Statutes, requires the Motor Carrier to execute the below

certification and return this report to: MOTOR CARRIER SAFETY SECTION

TEXAS DEPARTMENT OF PUBLIC SAFETY
PO BOX 4087

Ш

AUSTIN TX 78773-0521

| I CERTIFY THAT THE REQUIRED I CERTIFICATE HAVE BEEN SATISF | | | | HER SIDE OF THIS |
|--|-------------------------|-------------|---------------------|------------------|
| SIGNATURE OF REPAIRMAN: | NAME OF SHOP (GARA | \GE): | REPAIR WO | RK COMPLETED |
| Hell | CES She | op_ | DATE -8-07 | TIMEGAM |
| I CERTIFY THAT ALL VIOLATIONS TO ASSURE COMPLIANCE WITH I MOTOR CARRIERS AND DRIVERS | THE MOTOR CARRIER SAFET | HAVE BEEN (| CORRECTED AND ACTIO | |

IMPORTANT MESSAGES

HSE Manage

Any enforcement actions taken against you and any subsequent court actions are intended to secure compliance with the traffic laws and all other users of the highways. Failure to comply with your written promise to appear in court as made on this citation will constitute a separate offense with which you may be charged and result in warrants being issued for your arrest. The issuance of arrest warrants will make you subject to entry into the wanted persons file of this department. Failure to appear in court or failure to satisfy a judgement ordering payment of a fine and cost in the manner ordered by the court may result in the denial of renewal of your driver's license.

You may be able to require that this charge (Violations of Chapter 545, Transportation Code - Operation and Movement of Vehicles) be dismissed by taking a driving safety course. However, you will lose that right if you do not provide written notice to the court on or before your appearance date of your desire to do so.

A second or subsequent conviction of failure to maintain financial responsibility will result in the suspension of your driver's license and motor vehicle registration unless you file and maintain proof of financial responsibility with the Department of Public Safety for two (2) years from the date of conviction. The Department may waive the requirement to file proof of financial responsibility if you file satisfactory evidence with the Department showing that at the time this citation was issued the vehicle was covered by a liability insurance policy or that you were otherwise exempt from the requirements to provide evidence of financial responsibility.

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To obtain IFTA information contact the State of Texas Comptrollers Office at 1-800-252-1383 or visit their website at www.window.state.tx.us/taxinfo/fuels/ifta.html.



Equipment and Facility Work Order

| Date 6-8-07 | | |
|--|-------------------------|--------------------|
| Equipment Number or Description | CES Customer and damage | |
| TRL# 257 | uamage | - Only) |
| | | |
| Equipment Type or Area | | |
| Description of Job | NR | |
| | | |
| Description of Work Preformed | Cost of Parts | Labor Hours Worked |
| REPLACE LTR MARKER LIGHT CKECK All Lights | 1.86 | ,5 |
| | | |
| | | |
| | | |
| | | |
| | | |
| Shop Supplies | 500 | |
| Total Cost for Parts \$ 6.84 | | |
| Total Labor (hours x \$55.00) \$ <u> </u> | | |
| Total Cost to Complete Work & 2 / 12 - | | |



Equipment and Facility Work Order

| Date | |
|---|---|
| Equipment Number or Description | CES Customer and Job (for customer damage only) |
| <u>280</u> | |
| Equipment Type or Area | |
| Description of Job EXHAUST CEAK HEAD CIO | NR |
| | |
| Description of Work Preformed | Cost of Parts Labor Hours Worke |
| ADSUBT & TIBATEN FITS LOOK. REPLACED LOOSE EXPAUSI CLAMP/SIL | DE KILLE WOLL . 3 |
| Referen & FRONT HEAD CAMP (LOW BER | |
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| 5(10) Sipplies | 1000 |
| Total Cost for Parts \$33.3 Total Labor (hours x \$55.00) \$55\frac{\pi_0}{2} | CACI |

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| 3 | SOUTH MILE POST LOCATION 6 1207 2 TIME 1 WEATHER TRAFFIC TOUTE |
| | 14/46N SUS DICIC Bayon WORKERSPRESENT DELLEGIA |
| | NO mud Flap (Rossla) SPEEDLY |
| THIS IS NOT A PLEA OF GUALTH | |
| TAPLE 6 | REASON WARNING VEHICLE YES TYPE OF CONSENT INC. TO ARREST CONTRABAND YES TYPE OF DRUGS CURRENCY FOR STOP CITATIONS SEARCH NO SEARCH PC INVENTORY FOUND NO CONTRABAND WEAPONS OTHER |
| MSI SMI | OTHER CONDITIONS |
| ₹ 11 [7] | APPUNIQUES NO PENALTY FOR THE FOLLOWING OFFENSELS): |
| SIGNATURE | Defective socialing IFISO |
| Sign | OU ARE HEREBY NOTIFIED O APPEAR BEFORE |
| J | LUCRE CT. J. PCT 8 PLACE TELEPHONE TO TELEPHONE |

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Paid on Probablish and

DATE 07/02/2007

***** OFFICIAL RECEIPT ****

RECEIPT # 72146

*** MARK A. FOSTER ***

*** JUSTICE OF THE PEACE ***

TIME 10:07 PRECINCT 7

CASE # M07071673

RECEIVED OF: TAYLOR, MATTHEW

COMMENTS:

FOR: TAYLOR, MATTHEW

DESCRIPTION: NO MUD FLAPS/SAFETY GUARDS REQUIRED

VICKNAIR, E - DP

AMOUNT DUE \$172.00

AMOUNT PAID \$172.00

BALANCE \$.00

PAYMENT TYPE D

CHECK NO 259972

COLLECTED BY VB

TAYLOR, MATTHEW (b) (4)

| Vehicle Pursuant to authority contained in TRC Chapter 644 1 hereby declare 'Out of Service' the vehicle's with defects followed by "YES" in the Out of Service defects have been repaired and that vehicles have been repaired and the vehicles with have been repaired and the vehicles or operate any motor vehicle until the convergence of the repair of the repair of the repair of the repair of the repair of the repair of the repair of the repair of the repair of the repair of the repair of the repair of the repair of the repair of | TX07420AQ008 | TXDPS COMMERCIAL VEHICLE ENFORCE | EMENT CD# . 01 E1 01 0 |
|--|--|--|---|
| ACCIENT SACROSS CARACTER PROSE PROC DISTRICT PROCESS CARACTER | ☑ ARREST TKT ☐ 9 - 15 PASS. FOR HIRE | | CP#: 0151818 2 |
| COL SAMENOE CHAPTER DIVISION DOUBLE DO | <u>-</u> | en broc. 🖼 tumencesme | |
| LEGREE MC: ACMYCHTYSTYLP: ORGANICS: COMERCE | | | SCALE _ |
| ANDICATE Y STATE OF SERVICES CHARACTER C. S. SENTENDENTAL SERVICES CONCRETE C. S. SENTENDENTAL SERVICES CONCRETE C. S. SENTENDENTAL SERVICES CONCRETE SOLD SERVICES CONCR | DATE: 05/26/2007 TIME: 10 | :46 AM COUNTY: BRAZORIA HWY | : (2) SH-0298 IN BRAZORIA CO. (48 M.P.#: 504 |
| ONDER: C I S ENVIRONMENTAL SERVICES TROCKE: ODSTAGGE OF GROSS RD | | ene e e e e e e e e e e e e e e e e e e | USDOT#: 0869392 |
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| DRIVER Pursuant to authority contained in TRC Chapter 644 I hereby declare "Out of Service" the vehicle's with defects followed by "YES" in the Out of Service column of this report. No person shall remove the out of service applied to these vehicles or operate such vehicles until the out of service defects have been repaired and the vehicles have been restored to safe operating condition, or proper operating authority has been obtained. SEE CONTINUATION SHEET TROOFER COMMENTS: TESTING YES VIN (1) (4) TROOFER COMMENTS: DRIVER Pursuant to authority contained in TRC Chapter 644 I hereby notify and declare the driver named on this report Obtained Oper. Auth. B. Coeperate any motor vehicle until permit or require driver to drive or operate any motor vehicle until permit or require driver to drive or operate any motor vehicle until permit or require driver to drive or operate any motor vehicle until permit or require driver to drive or operate any motor vehicle until permit or require driver to drive or operate any motor vehicle until permit or require driver to drive or operate any motor vehicle until permit or require driver to drive or operate any motor vehicle until permit or require driver to drive or operate any motor vehicle until permit or require driver to drive or operate any motor vehicle until permit or require driver to drive or operate any motor vehicle until permit or require driver to drive or operate any motor vehicle until permit or require driver to drive or operate any motor vehicle until permit or require driver to drive or operate any motor vehicle until permit or require driver to drive or operate any motor vehicle until permit or require driver to drive or operate any motor vehicle until permit or require driver to drive or operate any motor vehicle until permit or require driver to drive or operate any motor vehicle until permit or require driver to drive or operate any motor vehicle until permit or require driver to drive or operate any motor vehicle until permit or require driver to | | | |
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| column of this report. No person shall remove the out of service stickers applied to these vehicles or operate such vehicles until the out of service defects have been repaired and the vehicles have been repaired and the vehicles have been repaired and the vehicles have been obtained. SEE CONTINUATION SKEET TROOFER COMMENTS: TESTING YES VIN (5) (4) TROOFER COMMENTS: ID/REGION/DISTRICT/AREA TIME COMPLETED REPORT PREPARED BY: ADAMS, BARRY LANE ADAMS, BARRY LANE OT 83 9 2 A 02 11:22AM REFERRAL ID | | | |
| applied to these vehicles or operate such vehicles until the out of service defects have been repaired and the vehicles have been restored to safe operating condition, or proper operating authority has been obtained. Dit of Service. No motor carrier shall permit or require driver to drive or operate any motor vehicle until D. Other U. Unknown N. Driver oos TESTING YES VIN (5) (4) And-e.s saro COPY RECEIVED BY: ID/REGION/DISTRICT/AREA TIME COMPLETED REPORT PREPARED BY: ADAMS, BARRY LANE ADAMS, BARRY LANE 07839 2 A 02 11:22AM DEDUTED SERVICE. No motor carrier shall permit or require driver to drive or operate any motor vehicle until D. Other Operate any motor vehicle until D. Other U. Unknown N. Driver oos COPY RECEIVED BY: ADAMS, BARRY LANE 1D/REGION/DISTRICT/AREA TIME COMPLETED REPORT PREPARED BY: ADAMS, BARRY LANE ADAMS, BARRY LANE 07839 2 A 02 11:22AM REFERRAL ID | 1 of pervice, the senitres and defects introved by | IPS IN the out of service INC Chapter | odd I nefeby notify and Hara Repaired at Scene / 1 |
| TESTING YES VIN (b) (4) And-e.s savo Copy Received By: ID/REGION/DISTRICT/AREA TIME COMPLETED REPORT PREPARED BY: ADAMS, BARRY LANE ADAMS, BARRY LANE 07839 2 A 02 11:22AM REFERRAL ID | applied to these vehicles or operate such vehicles defects have been repaired and the vehicles have b | until the out of service Out of Ser- een restored to safe operating permit or | vice. No motor carrier shall B. Towed/Escorted to require driver to drive or Repair Service |
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| ADAMS, BARRY LANE 07839 2 A 02 11:22AM REFERRAL ID |] | | CEIVED BY |
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| | | | |

ANY ENTRIES IN THE VIOLATIONS' SECTION OF DRIVER'S COPY, WHERE THERE IS "YES" IN THE TICKET BOX, INDICATES CHARGES FILED AGAINST THE DRIVER. THIS WILL REQUIRE CONTACTING THE JUDGE FOR APPROPRIATE DISPOSITION.

JUDGE INFORMATION IS IN HEAVY BORDERED BOX ON DRIVER'S COPY.

PAYMENTS FOR FINES SHOULD BE SENT TO THE COURT LISTED ON THE DRIVER'S COPY. DO NOT SEND PAYMENTS TO TX DPS/MCB.

CERTIFICATION OF REPAIRMAN

I CERTIFY THAT THE REQUIRED REPAIRS SHOWN IN THE "OUT OF SERVICE" COLUMN ON THE OTHER SIDE OF THIS CERTIFICATE HAVE BEEN SATISFACTORILY COMPLETED.

SIGNATURE OF REPAIRMAN:

NAME OF SHOP (GARAGE):

REPAIR WORK COMPLETED

DATE:

TIME:

5-28-07 Som

MOTOR CARRIER CERTIFICATION OF ACTION TAKEN

I CERTIFY THAT ALL VIOLATIONS NOTED UPON THIS REPORT HAVE BEEN CORRECTED AND ACTION HAS BEEN TAKEN TO ASSURE COMPLIANCE WITH THE MOTOR CARRIER SAFETY REGULATIONS INSOFAR AS THEY ARE APPLICABLE TO MOTOR CARRIERS AND DRIVERS.

SIGNATURE OF CARRIER OFFICIAL:

DATE:

HSE Manager

5-29-07

ATTENTION DRIVER:

This report must be furnished to the motor carrier whose name appears on this report.

ATTENTION DRIVER:

TRC Chapter 644, Revised Statutes, requires the Motor Carrier to execute the above certification

and return this report to:

MOTOR CARRIER BUREAU TEXAS DEPARTMENT OF PUBLIC SAFETY

PO BOX 4087

AUSTIN TX 78773-0521

IMPORTANT MESSAGES

Any enforcement actions taken against you and any subsequent court actions are intended to secure compliance with the traffic laws and all other users of the highways. Failure to comply with your written promise to appear in court as made on this citation will constitute a separate offense with which you may be charged and result in warrants being issued for your arrest. Failure to appear in court or failure to satisfy a judgement ordering payment of a fine and cost in the manner ordered by the court may result in the denial of renewal of your driver's license.

"A second or subsequent conviction of failure to maintain financial responsibility will result in the suspension of your driver license and motor vehicle registration unless you file and maintain proof of financial responsibility with the Department of Public Safety for two (2) years from the date of conviction. The Department may waive the requirements to file proof of financial responsibility if you file satisfactory evidence with the Department showing that at the time this citation was issued the vehicle was covered by a liability insurance policy or that you were otherwise exempt from the requirements to provide evidence of financial responsibility.

You may be able to require that this charge be dismissed by successfully completing a driving safety course or a motorcycle operator training course. You will lose that right if, on or before your appearance date, you do not provide the court with notice of your request to take the course. This article does not apply to an offense committed by a person who holds a commercial driver's license.

A request for an out-of-service review, regarding operating authority, must be made in writing and forwarded to the manager of the Motor Carrier Bureau. If requested, a review will be scheduled and conducted by the manager of the Motor Carrier Bureau or the director's designee within 10 days of the issuance of the out-of-service order. A request for review should be addressed to the Texas Department of Public Safety, Motor Carrier Bureau, P.O. Box 4087, Austin, TX 78773-0521 or may be sent by facsimile transmission to (512) 424-5712 or via electronic mail at MotorCarrierBureau@txdps,state.tx.us. The Department may conduct the review by telephone conference

To obtain a TxDOT Motor Carrier Insurance Certificate or Single State Registration - contact the Texas Department of Transportation at 1-800-299-1700 or visit their website at www.dot.state.tx.us.

To obtain a USDOT Number contact the Federal Motor Carrier Safety Administration at 1-800-832-5660 or visit their website at www.fmcsa.dot.gov/factsfigs/formspubs.htm.

To obtain IFTA information contact the State of Texas Comptrollers Office at 1-800-252-1383 or visit their website at www.window.state.tx.us/taxinfo/fuels/ifta.html.



Equipment and Facility Work Order

| Date <u>05 1 分から</u> / | | |
|---|------------------------|--------------------|
| Equipment Number or Description | CES Customer and damag | • |
| 207 | | |
| Equipment Type or Area | | |
| Description of Job BRAKES OUT OF ADJUSTED | CNT | |
| Description of Work Preformed | Cost of Parts | Labor Hours Worked |
| ADVISTED ALL BRAKE / REPEACED 10034 MANAR #3030 BRAKE CHAMBER 1524/EN | ort Corr. Filitials | 1,5 |
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| | | |
| | | |
| | | |
| Total Cost for Parts \$ Total Labor (hours x \$55.00) \$ Total Cost to Complete Work \$ | | Corres |

CES ENVIRONMENTAL SERVICES, INC.

4904 GRIGGS ROAD HOUSTON, TEXAS 77021 (713) 676-1460 BANK OF AMERICA, NA 35-2/1130 30924

6/20/2007

PAY TO THE ORDER OF _

Judge Wayne Dubose

\$ **125.00

One Hundred Twenty-Five and 00/100***

DOLLARS 🚹 🧱

Judge Wayne Dubose 111 E. Locust Room 110

Angleton, TX 77515

MEMO

CP # 0151818

(b) (4

30924

CES ENVIRONMENTAL SERVICES, INC.

Judge Wayne Dubose

Date Type 6/19/2007 Bill

Reference CP # 0151818 Original Amt. 125.00 6/20/2007 Balance Due Discour

ce Due Discount 125.00 Check Amount Payment 125.00 125.00

CES Environmental S CP # 0151818

125.00

form: eTicketO

Louisiana Department of Transportation and Development

Attn: Weights & Standards Office P.O. Box 94042, Baton Rouge, LA. 70804-9042

Issued the 25th day of June, 2007 at 08:25 AM Highway: I-10 W Parish: Calcasieu VT# 0701BW-40.RB01030(0) Driver Last Name: VANDENBERG, First Name; DAVID M.I. F Suffix; Street Address: (b) (4) City: (b) (4) Operator License Number: (b) (4) Class: A State of Issue: TX D.O.B. Owner DBA Name: STEVEN K STRICKER Name: ENVIRONMENTAL SERVICES INC Street Address: 4904 GRIGGS RD Street Addre City: HOUSTON, State: TX City ZIP: 77021 Phone: (b) (4) Vehicle Information Phone: (281) 433-7052 Is Apportioned Vehicle Year Vehicle Make Vehicle VIN Number Vehicle D.O.T number 2000 869392 **PTRB** License Number Registered Weight License Year License State 2007 ΤX (b) (4) 80,000 Primary Trailer Information 2nd Trailer Information Primary Trailer License No Primary Trailer State 2nd Trailer State 2nd Trailer License No ΤX NA NA Permit Information Expired 48 Hour Permit No. Valid 48 Hour Permit No. 731507 Expired Permit No. Valid Permit No. Control Number: Permitted Weight: 0 Commodity Code Description TANKER R.S. No. Violation: Description Fine \$200.00 47:511.1 No Temporary 48-Hour Trip Permit Tire width on steering axle: 11.00 No. Of Axles Sets: 3 Type: Type 6 Maximum allowable legal / permitted weight - Interstate: 80000 Non-interstate: 80000 Axle Set 1 Axle Set 2 Axle Set 3 Axle Set Steering Axle Tandem Tandem Type Legal Weight 15,000 34,000 34,000 Scale Weight 10,660 28,640 34,240 Over Weight 240 0 \$0.00 \$0.00 \$10.00 Fine Weight Table Fine Summary Over GVW lb Over GVW \$ Multiple Violation G.V.W. **GVW** Overage Individual Axle Fines Primary Fine \$10.00 \$0.00 73.540 \$0.00 \$10.00 Remarks: EXPIRED REGISTRATION -- NO TRIP PERMIT Total Fine Is: \$200.00 Violation Number: 0701BW-40.RB01030(0)

Officer

Raylen Bass

Paid on matts Credit Cand 7-6-07 Immediate payment may be made by the following options: MasterCard, Visa, or American Express Credit Cards, LA DOTD Approved Money Transfers, Posted Bond, Cash, Cashier's Check, Certified Check, Company Checks or Money Order made payable to LA DOTD. For information related to payment, please call (225) 377-7100.

Violation Tickets must be paid or protested as set forth in [1] and [3] within thirty (30) days of the issuance date on the VT. In the event payment of the fine has not received within 30 days, LA operators license information will be forwarded to the Motor Vehicle Division, Dept. of Public Safety for suspension, revocation, and cancellation; and the vehicle plate will be removed until the fine is paid.

Written protest of a Violation Ticket must be submitted within 30 days of issuance date. Upon receipt of a written protest, the VT will be scheduled for review in the regularly scheduled meetings of the Violation Ticket Review Committee. If additional information concerning protesting is needed, Please call (225) 377-7131.

LA DOTD Weights and Standards PO Box 94042 Baton Rouge, LA 70804-9042

0701BW-40.RB01030(0)

According to Louisiana Revised Statute 32:389, paragraphs 4 (a) (b) and (c) and 5:

"Any owner or driver resisting the payment of the penalty found due, or the enforcement of any provision of this Part In relation thereto, shall pay the amount of the penalty assessed to the Weights and Standards police officer, state policeman or other person designated in a license receipt and shall give this officer, state policeman or person notice at the time of payment of his intention to file suit for the recovery of such penalty."

"Any owner or driver who pays an assessed penalty under protest in accordance with the provisions of this Section shall have a period of ninety days after the date of payment to institute a civil suit against the department to recover the penalty so paid." "The right to sue for recovery of a penalty paid under protest shall afford a legal remedy and right of action in any state district court for a full and complete adjudication of any questions arising in the enforcement of a penalty respecting the legality of any penalty assessed or the method of enforcement thereof. Any such suit may be instituted either in the parish in which the violation occurred, the domicile of vehicle, provided the domicile is within the state of Louisiana, or in East Baton Rouge Parish. In any such suit, service of process shall be made on the Department, through the Secretary. The department shall be a necessary and proper party defendant in any such suit.

"No court of this state shall issue any process whatsoever to restrain the collection of any penalty assessed by the department pursuant to this Part."

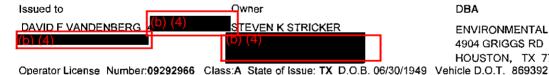
VIOLATION TICKET DOTD 03-44-0699 (REV. 09/01)

Please cut and include this stub with your payment

Louisiana Department of Transportation and Development

Attn: Weights & Standards Office

P.O. Box 94042, Baton Rouge, LA. 70804-9042



DBA

ENVIRONMENTAL SERVICES INC 4904 GRIGGS RD

HOUSTON, TX 77021

Violation Ticket Issued the 25th day of June, 2007 at 08:25 AM.

| Revised Statute Number | Description |
|------------------------------|--|
| 47:511.1 | No Temporary 48-Hour Trip Permit |
| Your Total Fine Is: \$200.00 | Violation Number: 0701BW-40.RB01030(0) |

Amount Enclosed: Payment Type: Date:

STATE OF LOUISIANA
DEPARTMENT OF TRANSPORTATION
AND DEVELOPMENT
CALCASIEU PARISH
I-10 WEST BOUND

TIME: 07:55:12am DATE: Jun 25 2007

STEERING: 10660 lb.
Drive: 28680 lb.
TRAILER: 34240 lb.

TOTAL: 73620 lb.

Waggoren 030176 82180 form: eTicketO

Louisiana Department of Transportation and Development

Attn: Weights & Standards Office P.O. Box 94042, Baton Rouge, LA. 70804-9042

Issued the 9th day of July, 2007 at 10:04 AM Highway: I-10 W Parish: Calcasieu VT# 0701BW-03.SH00534(0) Driver Last Name: WOOD, M.I. B Suffix: First Name: WILLIAM Street Address: (b) (4) City (b) (4 Operator License Number: class: A State of Issue: TX D.O.B. Owner DBA Name: STEVEN K STRICKER Name: CES ENVIRONMENTAL SVCS INC Street Address (b) (4) Street Address: 4904 GRIGGS RD City: City: HOUSTON, State: TX ZIP: 77021 Phone: (713) 679-1460 Phone: (b) Is Apportioned Vehicle Information Vehicle D.O.T number Vehicle Year Vehicle VIN Number Vehicle Make 1997 869392 PR License Year License State Registered Weight 80,000 2008 TX Primary Trailer Information 2nd Trailer Information 2nd Trailer State Primary Trailer State Primary 2nd Trailer License No NΑ NA TX Permit Information Valid 48 Hour Permit No. Expired 48 Hour Permit No. Expired Permit No. Valid Permit No. Permitted Weight: Control Number: Commodity Code Description LQ SODIUM HYDROXIDE Fine R.S. No. Violation: Description 32:386 1. Over Legal Gross Vehicle Weight or Over Legal Axle Weight \$0.00 Type: Type 6 Tire width on steering axle: 11.00 No. Of Axles Sets: 3 Maximum allowable legal / permitted weight - Interstate: 80000 Non-Interstate: 80000 Axle Set Axle Set 1 Axle Set 2 Axle Set 3 Type Steering Axle Tandem Tandem 34,000 34,000 Legal Weight 15,000 Scale Weight 10,740 35,560 32,280 Over Weight 1,560 \$0.00 Fine \$15.60 \$0.00 Weight Table Fine Summary Primary Fine **GVW** Overage Multiple Violation G.V.W. Over GVW lb Over GVW \$ Individual Axle Fines 78,580 \$0.00 \$15.60 \$15.60 \$0.00 Remarks: Driver was given the opportunity to shift, but was unable to legalize Violation Number: 0701BW-03.SH00534(0) Total Fine Is: \$15.60

Driver

WILLIAM B WOOD

Officer

Sarah G Hebert



Control Number: 0701BW-SH000715

Issued the 9th day of July, 2007 at 10:13 AM

V.T. 0701BW-03.SH00534(1)

| Highway | Parish | Statute | Issuing Officer |
|--|---------------------------|---------|---------------------------------------|
| I-10 | Calcasieu | 32:386 | Sarah G Hebert |
| Cash | | | |
| escription: PAID BY DRIVER | | | |
| | Staten | nent | |
| | Fine Amount | \$15.60 | |
| Amo | unt Paid (prior receipts) | \$0.00 | · · · · · · · · · · · · · · · · · · · |
| | Balance | \$15.60 | |
| <u>, </u> | mount of this payment | \$15.60 | |
| Balance | Due after this payment | \$0.00 | |
| | Payment | History | |
| No prior receipts. | | | |

Disposition Code: 02

| Driver | | | | | |
|-----------------|--------------|------------------------|-------------|----------------------------|--------------------|
| Name: WILLIAN | | | | | |
| | | WILLIAM M.I. B Suffix: | | | |
| Street Address: | (h) (4) | | _ | | |
| City: (b) (4) | | Phone: | | | |
| Operator Licens | e Number: | ass: A State of Issue: | TX | | |
| Owner | | | DBA | | |
| Name: STEVEN | | | Nam | e: CES ENVIRONMENTAL SVCS | INC |
| Street Address: | (b) (4) | | Stree | et Address: 4904 GRIGGS RD | |
| City (b) (4) | | | City: | HOUSTON, State: TX ZIP: 73 | 7021 |
| Phone: (D) (4) | | | Phor | ne: (713) 679-1460 | |
| Vehicle Year | Vehicle Make | Vehicle VIN Number | License Yea | ar License State | License Number |
| 1997 | PB | (b) (4) | 2008 | TX | (b) (4) |
| | | | | Trailer State | Trailer License No |
| | | | <u> </u> | TX | (b) (4) |

Receipt Issued by: Sarah G Hebert

STATE OF LOUISIANA DEPARTMENT OF TRANSPORTATION AND DEVELOPMENT CALCASIEU PARISH I-10 WEST BOUND

TIME: 09:57:15am DATE: Jul 09 2007

Weighment 1: 10740 lb Scale 1 Weighment 2: 35560 lb Scale 2 Weighment 3: 32280 lb Scale 3

TOTAL: 78580 lb

TARE TIME DATE

TOTAL: 78580 lb.

8693929-24 W38729-24

| TX075J0DBD02 | HARRIS COUNTY SHERIFF'S OFFICE | CP#: 0151818 2 |
|--|---|--|
| ☐ ARREST TKT ☐ 9 - 15 PASS. FOR HIRE ☐ COM. VEH. ☐ 16 PASS. FOR HIRE ☐ ACCIDENT ☐ 16 PASS. NOT FOR HIRE ☐ CDL ☐ SCHEDULE ☐ CHARTER | CONSTRUCTION SP PROG: ☑ INTERSTATE ☐ YES ☑ INTRASTATE ☐ OCCUPIED | ZONE FIXED PROADSIDE ALCH DS |
| DATE: 07/18/2007 TIME: 7: | DO AM COUNTY: HARRIS HWY: | (1) IH-0010 IN HARRIS CO. (742- M.P.#: 745 |
| LESSEE/MC: | | USDOT#: 0869392 |
| ADD/CITY/ST/2IP: | | ICC/MC#: 400234 |
| OWNER: C E S ENVIROMENTAL SERVICES | | TXDOT#: 005516524C |
| ADD/CITY/ST/ZIP: 4904 GRIGGS RD (3901 TRAIL | | PHONE#: 7136761460 |
| OPERATOR: ROLANDO MORALES | RACE/SEX: FIM DO | 11EB C12C0 01723/2000 |
| ADD/CITY/ST/ZIP: (0) (4) | DL #: | <u> </u> |
| VEH SEARCH: ☐ YES ☑ NO REASON FOR S | | |
| TYPE OF SEARCH: CONSENT PC INC. TO A | RREST INVENTORY TYPE OF CONTRABAND: | |
| SIGNATURE: THEREBY PROMISE TO APPEAR AT THE TIME AND | | (4) TX TX |
| PLACE DESIGNATED IN THIS NOTICE. (THIS IS NOT A PLEA OF GUILTY) | x 00 00 | |
| | —————————————————————————————————————— | GROUP WEIGHT: |
| ✓ COPY RECEIVED BY YOU ARE HEREBY NOTIFIED TO APPEAR | | DAD DISP: |
| JUDGE: COURT | . рст /эгале. | |
| PHONE: ON/BEFORE | PE | RMIT #: GVWR #1 80000 |
| ADDRESS: | | WT #2 GVWR #2 |
| SEAL #'S REMOVED: DEPT. SEAL #; INSTA | LLED CVSA DECAL-TT CVSA DECAL- | |
| | | - Allen |
| SHIPPING #: 001605821 | CONSIGNOR: HEXION SPECIALTY | CONSIGNEE: CES |
| COMMODITY: CHEMICALS | ORIGIN: CHEMICALS ORIGIN: BRADY T | DESTINATION: HOUSTON TX |
| | PLACARDS REQ? 11/4 | ALLEGED SPEED |
| BUT.K 9S | | SPEED LIMIT |
| | | 5 AX 6 AX 7 AX 8 RADAR CAL. |
| | 407 L | |
| TICKET VIOL. CITE # Unit OOS OOS POST No. Y/N DISP ACC | VIOLATIONS D | |
| | DRIVER: PLEASE COMPLY WITH DIRECTIONS ON DISPLAY LICENSE RECEIPT (COMMERCIAL MOTO | |
| | | |
| · | | |
| | | |
| | | • |
| | | |
| | | |
| \ | EHICLE/DRIVER OUT OF SERVICE NOTICE | |
| VEHICLE Pursuant to authority contained in TRC Chap of Service" the vehicle/s with defects followed by column of this report. No person shall remove the applied to these vehicles or operate such vehicles defects have been repaired and the vehicles have be condition, or proper operating authority has been of SEE CONTINUATION SHEET TROOPER COMMENTS: | "YES" in the Out of Service TRC Chapter 6 declare the dountil the out of service an restored to safe operating TRC chapter 6 declare the dountil the out of service permit or required. | nt to authority contained in 44 I hereby notify and A. Repaired at Scene / river named on this report e. No motor carrier shall lire driver to drive or otor vehicle until DOS DISPOSITIONS A. Repaired at Scene / Obtained Oper. Auth. B. Towed/Escorted to Repair Service D. Other U. Unknown N. Driver 005 |
| DRUG TEST <mark>YES</mark> UNIT 1 VIN 42276 | V | |
| | X | ☑ Log Book Exemption |
| THE PROPERTY OF THE PROPERTY O | COPY RECE | |
| | ISTRICT/AREA TIME COMPLETED REPORT PREPA 682 2 9 S 7:35AM REFERRAL ID | ······································ |
| CHARGES FILED BY: | | CTED BY: 28-026682 |

ANY ENTRIES IN THE VIOLATIONS' SECTION OF DRIVER'S COPY, WHERE THERE IS "YES" IN THE TICKET BOX, INDICATES CHARGES FILED AGAINST THE DRIVER. THIS WILL REQUIRE CONTACTING THE JUDGE FOR APPROPRIATE DISPOSITION.

JUDGE INFORMATION IS IN HEAVY BORDER BOX ON DRIVER'S COPY

PAYMENTS FOR FINES SHOULD BE SENT TO THE COURT LISTED ON THE DRIVERS COPY.

DO NOT SEND PAYMENTS TO TX DPS/MCB

CERTIFICATE OF REPAIRMAN I CERTIFY THAT THE REQUIRED REPAIRS SHOWN IN THE "OUT OF SERVICE" COLUMN ON THE OTHER SIDE OF THIS CERTIFICATE HAVE BEEN SATISFACTORILY COMPLETED. SIGNATURE OF REPAIRMAN: NAME OF SHOP (GARAGE): REPAIR WORK COMPLETED: DATE: TIME:

MOTOR CARRIER CERTIFICATION OF ACTION TAKEN

CERTIFY THAT ALL VIOLATIONS NOTED UPON THIS REPORT HAVE BEEN CORRECTED AND ACTION HAS BEEN TAKEN TO ASSURE COMPLIANCE WITH THE MOTOR CARRIER SAFETY REGULATIONS IN SO FAR AS THEY ARE APPLICABLE TO MOTOR CARRIERS AND DRIVERS.

SIGNATUREOF CARRIER OFFICIAL:

TITLE: HSE Manager

7-19-2007

ATTENTION DRIVER:

This report must be furnished to the motor carrier whose name appears on this report.

ATTENTION DRIVER:

TRC Chapter 644, Revised Statutes, requires the Motor Carrier to execute the above certification and return this report to:

MOTOR CARRIER SAFETY SECTION

MOTOR CARRIER SAFETY SECTION TEXAS DEPARTMENT OF PUBLIC SAFETY PO BOX 4087

AUSTIN TX 78773-0521

IMPORTANT MESSAGES

Any enforcement actions taken against you and any subsequent court actions are intended to secure compliance with the traffic laws and all other users of the highways. Failure to comply with your written promise to appear in court as made on this citation will constitute a separate offense with which you may be charged and result in warrants being issued for your arrest. Failure to appear in court or failure to satisfy a judgment ordering the payment of a fine and cost in the manner ordered by the court may result in the denial of renewal of your driver's license.

A second or subsequent conviction of failure to maintain financial responsibility will result in the suspension of your driver's license and motor vehicle registration unless you file and maintain proof of financial responsibility with the Department of Public Safety for two (2) years from the date of conviction. The Department may waive the requirement to file proof of financial responsibility if you file satisfactory evidence with the Department showing that at the time this citation was issued, the vehicle was covered by a liability insurance policy or that you were otherwise exempt from the requirements to provide evidence of financial responsibility.

You may be able to require that this charge be dismissed by successfully completing a driving safety motorcycle operator training course. You will lose that right if, on or before your appearance date, you do not provide the court with notice of your request to take the course. This article does not apply to an offense committed by a person who holds a commercial driver's license.

"A conviction of an offense under a traffic law of this state or a political subdivision of this state may result in the assessment on your driver's license of a surcharge under the Driver Responsibilty Program."

A request for an out-of-service review, regarding operating authority must be made in writing and forwarded to the manager of the Motor Carrier Bureau. If requested, a review will be scheduled and conducted by the manager of the Motor Carrier Bureau or the director's designee within 10 days of the issuance of the out-of-service order. A request for review should be addressed to the Texas Department of Public Safety, Motor Carrier Bureau, P.O. Box 4087, Austin, TX 78773-0521 or may be sent by facsimile transmission to (512)424-5712 or via electronic mail at Motor Carrier Bureau@txdp.state.tx.us. The department may conduct the review by telephone conference call.

To obtain a TXDOT Motor Carrier Insurance Certificate or Single State registration - contact the Texas Department of Transportation at 1-800-299-1700 or visit their website at www.dot.state.tx.us.

To obtain a USDOT Number contact the Federal Motor Carrier Safety Administration at 1-800-832-5660 or visit their website at www.fmcsa.dot.gov/factsfigs/formspubs.htm.

To obtain IFTA information contact the State of Texas Comptrollers Office at 1-800-252-1383 or visit their website at www.window.state.tx.us/taxinfo/fuels/ifta.html.

| TX075C0A | ВХ02 тх | DPS COMMERCIAL VEHICE | E ENFORCEMENT | CD# - 01 51 | O10 LEVEL |
|--|---|---|---|---|--|
| ARREST TKT COM. VEH. ACCIDENT CDL | ☐ 9 - 15 PASS. FOR HIRE ☐ 16 PASS. FOR HIRE ☐ 16 PASS. NOT FOR HIRE SP ☐ SCHEDULE ☐ CHARTER | PROG: INTERSTAT | CONSTRUCTION ZON THE MOST OF THE CONSTRUCTION ZON CONTROL OF THE CONSTRUCTION ZON | CP#: 0151 SCALE HOUSE 3A304 | |
| DATE: | | AM COUNTY: JACKSON | _ | US-0059 IN JACKSON CO. | |
| LESSEZ/MC: | | | ··— · <u></u> | USDOT | |
| ADD/CITY/ST/ZIP: | | | | ICC/MC | C#: 400234 |
| OWNER: CESEN | VIROMENTAL SERVICES | | | TXDOT | : 005516524C |
| ADD/CITY/ST/ZIP: | 4904 GRIGGS RD (3901 TRAILMON | BILE; HOUSTON TX 77013 | | PHONE | 7136761460 |
| OPERATOR: LUIS | MANUEL RESENDEZ | RACE/S | EX: HM DOB: | (b) (4) MED CA | ARD: |
| ADD/CITY/ST/ZIP: | (b) (4) | | DL #: (b |) (4) ST: TX | DL CLASS: A |
| VEH SEARCH: | es 🗹 no Reason for Sto | P: WARN CITATION | INSPECTION | CONTRABAND LOCATED | : ∐YES ∐NO |
| TYPE OF SEARCH: | CONSENT PC INC. TO ARR | EST INVENTORY TYPE | F CONTRABAND: E | DRUGS WEAPONS C | |
| X C 2</th <th>6</th> <th>1 TR CHEV</th> <th>CO# (b) (4)</th> <th>TX</th> <th></th> | 6 | 1 TR CHEV | CO# (b) (4) | TX | |
| | Α. | COO-XX ROSS WEIGHT: | GROO | UP WEIGHT: | |
| YOU ARE HEREBY NO | | | LCAD | DISP: | |
| JUDGE: R W BOBBY | DOELITSCH COURT: JP | PCT./PLAC | E: 1/0 PERMI | т и. | · |
| PHONE: (361) 782 | -5259 ON/BEFORE' 27-Jul- | | PERMI | | VR #1 17500 |
| ADDRESS: 411 N WEL | L9 RM 302 EDNA TX 77957 | | 1.0 "- | L i | IR #2 |
| SEAL #'S REMOVED: | DEPT. SEAL #; INSTALLE | ED CVSA DECAL-TT | CVSA DECAL-ST | CVSA DECAL-ST | T |
| | | | | | |
| SHIPPING #: | | ONSIGNOR: CES ENVIRONN | ENTAL | CES ENVI | RONMENTAL |
| ł | GAL TANK W/STAND | SERVICES HOUSTON | TX | CONSIGNEE: SERVICES PORT LAV | · |
| COMMODITY: | | RIGIN: | | DESTINATION: | |
| | HM CATEGORY CODE RQ? HW? P | LACARDS REQ? | | ļ i | D SPEED |
| | <u> </u> | SPEC. TANK AX 1 AX 2 | AX 3 AX 4 AX 5 | AX 6 AX 7 AX 8 RADAR | |
| TICKET VIOL. CITE # | Unit OOS Y/ OOS POST | <u> </u> | VIOLATIONS DISCO | OVERED | <u> </u> |
| \$96.17(c) | | RIVER: PLEASE COMPLY WITH CMV INSPECTION CERTIFI | | | |
| ies | 2 EXPIRED | CHY INSPECTION CERTIFI | CAIL / ANNOAL L | \$11,00 | 100 |
| Yes)393.95(f) | 1 DEFECTIV | VE/IMPROPER WARNING DEV | TCE - NO WARNIN | G DEVICE | 150 AN |
| | 1 FAIL TO D | ISPLAY LICENSE RECEIPT (C | OMMERCIAL MOTOR V | EHICLE) - | · |
| | | HICLE/DRIVER OUT OF SER | | | |
| of Service the ver- column of this repr applied to these videfects have been a condition, or property SEE CONTINUATION SHO | | of service stickers il the out of service restored to safe operating sined. | declare the driver Out of Service, No | hereby notify and named on this report named on this report noter carrier shall driver to drive or vehicle until | DOS DISPOSITIONS A. Repaired at Scene / Obtained Oper. Auth. B. Towed/Escorted to Repair Service D. Other U. Unknown N. Driver OOS |
| #1VIN 6 22 2VIN: NO EMERGENCY WARNING | O (4) - TRAILER HAS NO CMV INS | PERCITOR - VENTUE HAS | X h +Rf | ВУ | Log Book Exemption |
| INSPECTED BY: | i i | TRICT/ARSA TIME COMPLETE: | REPORT PREPARED | | |
| HARP, MELVIN H CHARGES FILED BY:] | 06355 3 ARF, MELVIN H 06355 3A03 | | REFERRAL ID BRAKES INSPECTED | 39. | |

CES ENVIRONMENTAL SERVICES, INC.

4904 GRIGGS ROAD HOUSTON, TEXAS 77021 (713) 676-1460

BANK OF AMERICA, NA 35-2/1130

31423

7/19/2007

PAY TO THE ORDER OF _ R W Bobby Doelitsch, JP **\$** **160.00

One Hundred Sixty and 00/100*

. DOLLARS 🚹 🎆

R W Bobby Doelitsch, JP 411 N Wells RM 302 Edna, TX 77957

MENO

fine for Luis Resendez TX075COABX02/CP0151818 #O31423#

31423

CES ENVIRONMENTAL SERVICES, INC.

R W Bobby Doelitsch, JP

Date 7/19/2007

Туре Reference

Original Amt. 160.00 Balance Due 160.00

Discount Check Amount

7/19/2007

Payment 160.00 160.00

CES Environmental S fine for Luis Resendez

160.00



LOUISIANA DEPARTMENT OF PUBLIC SAFETY AND CORRECTIONS OFFICE OF MOTOR VEHICLES TEMPORARY PERMIT (48-HR.)

| PERMIT EXPIRES | | | Numbe | <u>r</u> |
|-------------------------------------|-------------------------------|-----------------------------------|------------------------|---------------------|
| 08:45 AM 06/27/2007 | | | LA. 73 | 1507 |
| Effective Date: | Issued by: | | Issue | Date: |
| 06/25/2007 | Raylen Bass Office: 0701BW | | 06/25 | /2007 |
| The Fee for This Permit Is: \$50.00 | NOTE: ANY ALTE OR MEAN | RATION OF THIS S USED, VOIDS T | | RDLESS OF TYPE |
| Owner STEVEN K STRICKER | | Operator DAVID F VANDE | NBERG | |
| Local Address (Residence | or Business) | | | |
| Street: | | | | |
| (b) (4) | | | | |
| City: | State: | | 70 | |
| (b) (4) | (D) | | (D) (4) | |
| (b) (4) | • • | | Bod y Style | Make |
| | | 00 | 6 | PTRB |
| Registered State TX | | ity ETON | | ense Number 3J10 |
| | ANGL | ETON | N9C | טוטכ |
| THIS PERMIT MUST | BE IN THE POSSESS | ION OF THE VEHIC | LE OPERATOR A | T ALL TIMES |
| Total Due \$50 | 0.00 Amount Paid | \$0.00 | Balance Due | \$50.00 |
| Payment History | | | | |

Officer: Raylen Bass

Remarks:



MECEN I OF TATMENT

Control Number: 0701BW-RB001005-48

Issued the 25th day of June, 2007 at 08:46 AM

| | Perr | nit Number: 73 | 31507 | | | |
|----------|--|-----------------|-------------|----------|--------------|---------|
| Driver: | DAVID F VANDENBERG | | Highway: I- | 0 Parist | n: Calcasieu | |
| Officer: | Raylen Bass | | Statute: | | | |
| | ceipt Amount Paid \$50.00 ow Due \$0.00 | i. | Paid By: Ca | | MIT | |
| | | Payment History | | | | |
| | | | Amt | St Chg | Amt Paid | Paid by |

Issued by: Raylen Bass 06/25/2007 08:46 AM

| TX075C0ABX02 | TYDES COMMERCIAL VEHICLE ENECDEEMENT | LEVEL |
|--|--|--|
| ARREST TKT 9 - 15 PASS. FOR HIRE | TXDPS COMMERCIAL VEHICLE ENFORCEMENT | CP#: 0151818 2 |
| COM. VEH. 🔲 16 PASS. FOR HIRE | CONSTRUCTION ZON | |
| ACCIDENT 16 PASS. NOT FOR HIRE COL SCHEDULE CHARTER | SP PROG: INTERSTATE YES NO | SCALE HOUSE 3A304 |
| 1 | INTRASTATE OCCUPIED 34 AM COUNTY: JACKSON HWY: (2) | HOUSE 3A304 SW TE US-0059 IN JACKSON CO. (600 M.P.#: 620 |
| La see/MC: | in (2) | USDOT#: 0869392 |
| AD/CITY/ST/ZIP: | The second secon | ICC/MC#: 400234 |
| OWER: C E S ENVIROMENTAL SERVICES | | TXDOT#: 005516524C |
| AD/CITY/ST/ZIP: 4904 GRIGGS RD (3901 TRAII | LMOBILE) HOUSTON TX 77013 | PHONE#: 7136761460 |
| OMRATOR: LUIS EMANUEL RESENDEZ | RACE/SEX: HM DOB: | (b) (4) MED CARD: |
| AD/CITY/ST/ZIP: (b) (4) | DL # .(b) | ST: TX DL CLASS: A |
| VB SEARCH: ☐ YES ☑ NO REASON FOR : | STOP: WARN CITATION CINSPECTION | CONTRABAND LOCATED: YES NO |
| TYPE OF SEARCH: CONSENT PC INC. TO. | ARREST INVENTORY TYPE OF CONTRABAND: | DRUGS WEAPONS CURRENCY OTHER |
| | UNIT TYPE MAKE CO# | ST |
| 1-06 | 1 TR CHEV 107 (b) (4) | TX |
| x h xpf | 2 ST OTHR 202 | |
| Z 1 | | of a differ in the management status it a sing of the distribution of the contract of the cont |
| SIGNATURE: | | |
| ☑ : HEREBY PROMISE TO APPEAR AT THE TIME AND ILACE DESIGNATED IN THIS NOTICE. (THIS IS | _ | |
| NOT A PLEA OF GUILTY) | x-0xx | • |
| ☑ COPY RECEIVED BY | GROSS WEIGHT: GROV | JP WEIGHT: |
| YOU ARE HEREBY NOTIFIED TO APPEAR | LOAD | DISP: |
| JUDGE: R W BOBBY DOELITSCH COURT: JP | PCT./PLACE: 1/0 PERMI | T#: |
| PHOME: (361) 782-5259 ON/BEFORE 27-J | Jul-2007 AT 10:00AM RG WT | #1 44000 GVWR #1 17500 |
| ADDRESS: 411 N WELLS RM 302 EDNA TX 77957 | RG WT | #2 0000 GVWR #2 |
| GEAL #'S REMOVED: DEPT. SEAL #; INSTA | ALLED CVSA DECAL-TT CVSA DECAL-ST | CVSA DECAL-ST |
| | | |
| | | |
| SHIPPING #: | CONSIGNOR: CES ENVIRONMENTAL SERVICES | CES ENVIRONMENTAL CONSIGNEE: SERVICES |
| | CONSIGNOR: SERVICES | COME TOMES . |
| SHIPPING #: COMMODITY: 1500 GAL TANK W/STAND | CONSIGNOR: SERVICES ORIGIN: HOUSTON TX PLACARDS REQ? | CONSIGNEE: SERVICES PORT LAVACA TX |
| SHIPPING #: COMMODITY: 1500 GAL TANK W/STAND | CONSIGNOR: SERVICES ORIGIN: HOUSTON TX PLACARDS REQ? R | CONSIGNEE: SERVICES DESTINATION: PORT LAVACA TX ALLEGED SPEED SPEED LIMIT |
| SHIPPING #: COMMODITY: 1500 GAL TANK W/STAND HM CATEGORY CODE RQ? HW? | CONSIGNOR: SERVICES ORIGIN: HOUSTON TX PLACARDS REQ? R | CONSIGNEE: SERVICES DESTINATION: PORT LAVACA TX ALLEGED SPEED |
| SHIPPING #: COMMODITY: 1500 GAL TANK W/STAND HM CATEGORY CODE RQ? HW? | CONSIGNOR: SERVICES ORIGIN: HOUSTON TX PLACARDS REQ? R SPEC. TANK AX 1 AX 2 AX 3 AX 4 AX 5 | CONSIGNEE: SERVICES DESTINATION: PORT LAVACA TX ALLEGED SPEED SPEED LIMIT AX 6 AX 7 AX 8 RADAR CAL. |
| SHIPPING #: COMMODITY: 1500 GAL TANK W/STAND HM CATEGORY CODE RQ? HW? NA PICKET VIOL. CITE # Unit OOS Y/ OOS POST No. N DISP ACC | CONSIGNOR: SERVICES ORIGIN: HOUSTON TX PLACARDS REQ? R SPEC. TANK L VIOLATIONS DISC | DESTINATION: SERVICES DESTINATION: PORT LAVACA TX ALLEGED SPEED SPEED LIMIT AX 6 AX 7 AX 8 RADAR CAL. DVERED |
| SHIPPING #: COMMODITY: 1500 GAL TANK W/STAND HM CATEGORY CODE RQ? HW? NA PICKET VIOL. CITE # Unit OOS Y/ OOS POST No. N DISP ACC | CONSIGNOR: SERVICES ORIGIN: HOUSTON TX PLACARDS REQ? R SPEC. TANK L VIOLATIONS DISC | DESTINATION: SERVICES DESTINATION: PORT LAVACA TX ALLEGED SPEED LIMIT AX 6 AX 7 AX 8 RADAR CAL. DVERED K SIDE OF THIS FORM DOT - NO INSPECTION |
| SHIPPING #: COMMODITY: 1500 GAL TANK W/STAND HM CATEGORY CODE RQ? HW? NA | CONSIGNOR: SERVICES ORIGIN: HOUSTON TX PLACARDS REQ? R SPEC. TANK AX 1 AX 2 AX 3 AX 4 AX 5 L VIOLATIONS DISC | DESTINATION: PORT LAVACA TX ALLEGED SPEED LIMIT AX 6 AX 7 AX 8 RADAR CAL. DVERED K SIDE OF THIS FORM OUT - NO INSPECTION |
| SHIPPING #: COMMODITY: 1500 GAL TANK W/STAND HM CATEGORY CODE RQ? MW? NA PICKET VIOL. CITE # Unit 005 Y/ 005 FOST No. N DISP ACC Yes 96.17(c) 2 EXPIRE Yes 393.95(f) 1 | CONSIGNOR: SERVICES ORIGIN: HOUSTON TX PLACARDS REQ? R SPEC. TANK L VIOLATIONS DISC DRIVER: PLEASE COMPLY WITH DIRECTIONS ON BAC ED CMV INSPECTION CERTIFICATE / ANNUAL I | DESTINATION: PORT LAVACA TX ALLEGED SPEED SPEED LIMIT AX 6 AX 7 AX 8 RADAR CAL. DVERED K SIDE OF THIS FORM DOT - NO INSPECTION G DEVICE |
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| SHIPPING #: COMMODITY: 1500 GAL TANK W/STAND HM CATEGORY CODE RQ? MW? NA PICKET VIOL. CITE # Unit 005 Y/ 005 FOST No. N DISP ACC Yes 96.17(c) 2 EXPIRE Yes 393.95(f) 1 | CONSIGNOR: SERVICES ORIGIN: HOUSTON TX PLACARDS REQ? R SPEC. TANK L VIOLATIONS DISC DRIVER: PLEASE COMPLY WITH DIRECTIONS ON BAC ED CMV INSPECTION CERTIFICATE / ANNUAL I | DESTINATION: PORT LAVACA TX ALLEGED SPEED SPEED LIMIT AX 6 AX 7 AX 8 RADAR CAL. DVERED K SIDE OF THIS FORM DOT - NO INSPECTION G DEVICE |
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| SHIPPING #: COMMODITY: 1500 GAL TANK W/STAND HM CATEGORY CODE RQ? MW? NA PICKET VIOL. CITE # Unit 005 Y/ 005 FOST No. N DISP ACC Yes 96.17(c) 2 EXPIRE Yes 393.95(f) 1 DEFECT | CONSIGNOR: SERVICES ORIGIN: HOUSTON TX PLACARDS REQ? R SPEC. TANK L VIOLATIONS DISC DRIVER: PLEASE COMPLY WITH DIRECTIONS ON BAC ED CMV INSPECTION CERTIFICATE / ANNUAL I TIVE/IMPROPER WARNING DEVICE - NO WARNING OD DISPLAY LICENSE RECEIPT (COMMERCIAL MOTOR V | DESTINATION: PORT LAVACA TX ALLEGED SPEED SPEED LIMIT AX 6 AX 7 AX 8 RADAR CAL. DVERED K SIDE OF THIS FORM DOT - NO INSPECTION G DEVICE |
| SHIPPING #: COMMODITY: 1500 GAL TANK W/STAND HM CATEGORY CODE RQ? MW? NA | CONSIGNOR: SERVICES ORIGIN: HOUSTON TX PLACARDS REQ? R SPEC. TANK L VIOLATIONS DISC DRIVER: PLEASE COMPLY WITH DIRECTIONS ON BAC ED CMV INSPECTION CERTIFICATE / ANNUAL I TIVE/IMPROPER WARNING DEVICE - NO WARNING ODISPLAY LICENSE RECEIPT (COMMERCIAL MOTOR V | DESTINATION: PORT LAVACA TX ALLEGED SPEED SPEED LIMIT AX 6 AX 7 AX 8 RADAR CAL. DVERED K SIDE OF THIS FORM DOT - NO INSPECTION AG DEVICE EHICLE) |
| SHIPPING #: COMMODITY: 1500 GAL TANK W/STAND HM CATEGORY CODE RQ? HW? NA PICKET VIOL. CITE # Unit OOS Y/ OOS POST No. | CONSIGNOR: SERVICES ORIGIN: HOUSTON TX PLACARDS REQ? R SPEC. TANK L VIOLATIONS DISC DRIVER: PLEASE COMPLY WITH DIRECTIONS ON BAC ED CMV INSPECTION CERTIFICATE / ANNUAL I TIVE/IMPROPER WARNING DEVICE - NO WARNING OD DISPLAY LICENSE RECEIPT (COMMERCIAL MOTOR V VEHICLE/DRIVER OUT OF SERVICE NOTICE pter 644 I hereby declare "Out TRC Chapter 644 I out of service stickers TRC Chapter 644 I | DESTINATION: ALLEGED SPEED SPEED LIMIT |
| SHIPPING #: COMMODITY: 1500 GAL TANK W/STAND HM CATEGORY CODE RQ? HW? NA | CONSIGNOR: SERVICES ORIGIN: HOUSTON TX PLACARDS REQ? R SPEC. TANK L VIOLATIONS DISC DRIVER: PLEASE COMPLY WITH DIRECTIONS ON BAC ED CMV INSPECTION CERTIFICATE / ANNUAL I TIVE/IMPROPER WARNING DEVICE - NO WARNING OD DISPLAY LICENSE RECEIPT (COMMERCIAL MOTOR V VEHICLE/DRIVER OUT OF SERVICE NOTICE Pier 644 hereby declare "Out of Service out of service stickers until the out of Service out of service stickers until the out of service with the out of | DESTINATION: ALLEGED SPEED |
| SHIPPING #: COMMODITY: 1500 GAL TANK W/STAND FICKET VIOL. CITE # Unit 008 Y/ 008 POST NA. NA. PASS 396.17(0) 2 Yes 393.95(f) 1 VERICLE Fursuant to authority contained in TRC Onar of Service" the vehicle/s with defects followed by column of this report. No person shall remove the applied to these vehicles or operate such vehicles | CONSIGNOR: SERVICES ORIGIN: HOUSTON TX PLACARDS REQ? R SPEC. TANK L VIOLATIONS DISC DRIVER: PLEASE COMPLY WITH DIRECTIONS ON BAC ED CMV INSPECTION CERTIFICATE / ANNUAL I TIVE/IMPROPER WARNING DEVICE - NO WARNING OD DISPLAY LICENSE RECEIPT (COMMERCIAL MOTOR V VEHICLE/DRIVER OUT OF SERVICE NOTICE Pier 644 hereby declare "Out of Service out of service stickers until the out of Service out of service stickers until the out of service with the out of | DESTINATION: ALLEGED SPEED SPEED LIMIT AX 6 AX 7 AX 8 RADAR CAL. DVERED K SIDE OF THIS FORM OOT - NO INSPECTION SPECTION A CAL A CAL O authority contained in hereby notify and named on this report of motor carrier shall driver to drive or vehicle until O construction of the contained of the control of the contro |
| SHIPPING #: COMMODITY: 1500 GAL TANK W/STAND MM CATEGORY CODE RQ? MW? NA PICKET VIOL. CITE # Unit 005 Y/ 005 POST NO. N DISP ACC EXPIRE Yes 393.95(f) 1 DEFECT 1 FAIL TO VERICLE Fursuant to authority contained in TRC Chap of Service" the vehicle/s with defects followed by column of this report. No person Shall remove the applied to these vehicles or operate such vehicles defects have been repaired and the vehicles have be condition, or proper operating authority has been condition. SEE CONTINUATION SHEET TROOPER COMMENTS: IVI (5) (4) #2VIN:018614 TRAILER HAS NO CMV | CONSIGNOR: SERVICES ORIGIN: HOUSTON TX PLACARDS REQ? R SPEC. TANK L VIOLATIONS DISC DRIVER: PLEASE COMPLY WITH DIRECTIONS ON BAC ED CMV INSPECTION CERTIFICATE / ANNUAL I TIVE/IMPROPER WARNING DEVICE - NO WARNING OD DISPLAY LICENSE RECEIPT (COMMERCIAL MOTOR V VEHICLE/DRIVER OUT OF SERVICE NOTICE PUTER 644 I hereby declare "Out TRC Chapter 644 I declare the drive until the out of Service until the out of service stickers until the out of service are restored to safe operating obtained. INSPECTION - VEHICLE HAS | DESTINATION: ALLEGED SPEED SPEED LIMIT AX 6 AX 7 AX 8 RADAR CAL. DVERED K SIDE OF THIS FORM OOT - NO INSPECTION HERD SPEED LIMIT AX 6 AX 7 AX 8 RADAR CAL. O'S DISPOSITIONS A. Repaired at Scene / Obtained on this report of mende on this report of motor carrier shall driver to drive or wehicle until |
| SHIPPING #: COMMODITY: 1500 GAL TANK W/STAND COMMODITY: HM CATEGORY CODE RQ? MW? NA PICKET VIOL. CITE # Unit 008 Y/ 008 POST No. N DISP ACC Yes 393.95(f) 1 VERICLE Fursuant to authority contained in TAC Char of Service the vehicle/s with defects followed by column of this report. No person shall remove the applied to these vehicles or operate such vehicles have been condition, or proper operating authority has been condition, or proper operating authority has been condition, or proper operating authority has been condition. | CONSIGNOR: SERVICES ORIGIN: HOUSTON TX PLACARDS REQ? R SPEC. TANK L VIOLATIONS DISC. DRIVER: PLEASE COMPLY WITH DIRECTIONS ON BACK ED CMV INSPECTION CERTIFICATE / ANNUAL I TIVE/IMPROPER WARNING DEVICE - NO WARNING ODISPLAY LICENSE RECEIPT (COMMERCIAL MOTOR V VEHICLE/DRIVER OUT OF SERVICE NOTICE PTES" in the Out of Service out of service stickers out of service stickers until the out of service while the out of service sen restored to safe operating obtained. | DESTINATION: ALLEGED SPEED |
| SHIPPING #: COMMODITY: 1500 GAL TANK W/STAND MM CATEGORY CODE RQ? MW? NA PICKET VIOL. CITE # Unit 005 Y/ 005 POST NO. N DISP ACC EXPIRE Yes 393.95(f) 1 DEFECT 1 FAIL TO VERICLE Fursuant to authority contained in TRC Chap of Service" the vehicle/s with defects followed by column of this report. No person Shall remove the applied to these vehicles or operate such vehicles defects have been repaired and the vehicles have be condition, or proper operating authority has been condition. SEE CONTINUATION SHEET TROOPER COMMENTS: IVI (5) (4) #2VIN:018614 TRAILER HAS NO CMV | CONSIGNOR: SERVICES ORIGIN: HOUSTON TX PLACARDS REQ? R SPEC. TANK L VIOLATIONS DISC DRIVER: PLEASE COMPLY WITH DIRECTIONS ON BAC ED CMV INSPECTION CERTIFICATE / ANNUAL I TIVE/IMPROPER WARNING DEVICE - NO WARNING OD DISPLAY LICENSE RECEIPT (COMMERCIAL MOTOR V VEHICLE/DRIVER OUT OF SERVICE NOTICE PUTER 644 I hereby declare "Out TRC Chapter 644 I declare the drive until the out of Service until the out of service stickers until the out of service are restored to safe operating obtained. INSPECTION - VEHICLE HAS | DESTINATION: ALLEGED SPEED |
| SHIPPING #: COMMODITY: 1500 GAL TANK W/STAND HM CATEGORY CODE RQ? HW? NA | CONSIGNOR: SERVICES ORIGIN: HOUSTON TX PLACARDS REQ? R SPEC. TANK L VIOLATIONS DISC. DRIVER: PLEASE COMPLY WITH DIRECTIONS ON BACK ED CMV INSPECTION CERTIFICATE / ANNUAL I TIVE/IMPROPER WARNING DEVICE - NO WARNING ODISPLAY LICENSE RECEIPT (COMMERCIAL MOTOR V VEHICLE/DRIVER OUT OF SERVICE NOTICE PTER 644 I hereby declare "Gut "YES" in the Out of Service out of Service stickers until the out of service stickers until the out of service stickers of the permit of require obtained. INSPECTION - VEHICLE HAS | DESTINATION: ALLEGED SPEED |

ANY ENTRIES IN THE VIOLATIONS' SECTION OF DRIVER'S COPY, WHERE THERE IS "YES" IN THE TICKET BOX, INDICATES CHARGES FILED AGAINST THE DRIVER. THIS WILL REQUIRE CONTACTING THE JUDGE FOR APPROPRIATE DISPOSITION.

JUDGE INFORMATION IS IN HEAVY BORDERED BOX ON DRIVER'S COPY.

PAYMENTS FOR FINES SHOULD BE SENT TO THE COURT LISTED ON THE DRIVER'S COPY. DO NOT SEND PAYMENTS TO TX DPS/MCB.

CERTIFICATION OF REPAIRMAN I CERTIFY THAT THE REQUIRED REPAIRS SHOWN IN THE "OUT OF SERVICE" COLUMN ON THE OTHER SIDE OF THIS CERTIFICATE HAVE BEEN SATISFACTORILY COMPLETED. SIGNATURE OF REPAIRMAN: REPAIR WORK COMPLETED NAME OF SHOP (GARAGE): DATE: TIME: 12-07 0 Am MOTOR CARRIER CERTIFICATION OF ACTION TAKEN I CERTIFY THAT ALL VIOLATIONS NOTED UPON THIS REPORT HAVE BEEN CORRECTED AND ACTION HAS BEEN TAKEN TO ASSURE COMPLIANCE WITH THE MOTOR CARRIER SAFETY REGULATIONS INSOFARAS THEY ARE APPLICABLE TO MOTOR CARRIERS AND DRIVERS. SIGNATURE OF CARRIER OFFICIAL: TITLE: DATE: 1-12-07 HSE Manager

ATTENTION DRIVER:

- Ph

This report must be furnished to the motor carrier whose name appears on this report.

ATTENTION DRIVER:

TRC Chapter 644, Revised Statutes, requires the Motor Carrier to execute the above certification

MOTOR CARRIER BUREAU and return this report to:

TEXAS DEPARTMENT OF PUBLIC SAFETY

PO BOX 4087

AUSTIN TX 78773-0521

IMPORTANT MESSAGES

Any enforcement actions taken against you and any subsequent court actions are intended to secure compliance with the traffic laws and all other users of the highways. Failure to comply with your written promise to appear in court as made on this citation will constitute a separate offense with which you may be charged and result in warrants being issued for your arrest. Failure to appear in court or failure to satisfy a judgement ordering payment of a fine and cost in the manner ordered by the court may result in the denial of renewal of your driver's license.

"A second or subsequent conviction of failure to maintain financial responsibility will result in the suspension of your driver license and motor vehicle registration unless you file and maintain proof of financial responsibility with the Department of Public Safety for two (2) years from the date of conviction. The Department may waive the requirements to file proof of financial responsibility if you file satisfactory evidence with the Department showing that at the time this citation was issued the vehicle was covered by a liability insurance policy or that you were otherwise exempt from the requirements to provide evidence of financial responsibility.

You may be able to require that this charge be dismissed by successfully completing a driving safety course or a motorcycle operator training course. You will lose that right if, on or before your appearance date, you do not provide the court with notice of your request to take the course. This article does not apply to an offense committed by a person who holds a commercial driver's license.

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To obtain IFTA information contact the State of Texas Comptrollers Office at 1-800-252-1383 or visit their website at www.window.state.tx.us/taxinfo/fuels/ifta.html.

| TX075J0DBD02 | HARRIS COUNTY SHERIFF'S OFFICE | CD# . 01E1010 |
|---|---|---|
| ☐ ARREST TKT ☐ 9 - 15 PASS. FOR HIRE | • | CP#: 0151818 2 |
| COM. VEH. 16 PASS. FOR HIRE | CONSTRUCTION ZON | |
| ☐ ACCIDENT ☐ 16 PASS. NOT FOR HIRE ☑ CDL ☐ SCHEDULE ☐ CHARTER | SP PROG: INTERSTATE YES NO INTRASTATE OCCUPIED | SCALE HOUSE SW TE |
| | | HOUSE SW TE IH-0010 IN HARRIS CO. (742- M.P.#: 745 |
| LESSEE/MC: | oo ar coodiii dadaab | USDOT#: 0869392 |
| ADD/CITY/ST/ZIP: | | ICC/MC#: 400234 |
| OWNER: C E S ENVIROMENTAL SERVICES | | TXDOT#: 005516524C |
| ADD/CITY/ST/ZIP: 4904 GRIGGS RD (3901 TRAIL | MORTIE) HOUSTON TY 77013 | Annual 11 11 11 11 11 11 11 11 11 11 11 11 11 |
| OPERATOR: ROLANDO MORALES | RACE/SEX: HM DOB: | PHONE#: 7136761460 (b) (4) MED CARD: 07/15/2008 |
| ADD/CITY/ST/2IP: (D) (4) | | (4) ST: TX DL CLASS: A |
| VEH SEARCH: ☐ YES ☑ NO REASON FOR | | CONTRABAND LOCATED: YES NO |
| TYPE OF SEARCH: CONSENT PC INC. TO | | |
| TYPE OF SEARCH: CONSENT DEC INC. TO | ARREST ☐ INVENTORY TYPE OF CONTRABAND: [UNIT TYPE MAKE CO# PLATE | |
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| PLACE DESIGNATED IN THIS NOTICE. (THIS IS NOT A PLEA OF GUILTY) | x 00 00 | |
| COPY RECEIVED BY | GROSS WEIGHT: GRO | UP WEIGHT: |
| YOU ARE HEREBY NOTIFIED TO APPEAR | ILOAD | DISP: |
| JUDGE: COUR | POT /PLACE | |
| PHONE: ON/BEFORE | AT RG W | |
| ADDRESS: | RG W | |
| SEAL #'S REMOVED: DEPT. SEAL #; INSTA | | CVSA DECAL-ST |
| | | |
| 001605821 | HEXION SPECIALTY | CES |
| SHIPPING #: CHEMICALS | CONSIGNOR: CHEMICALS BRADY TX | CONSIGNEE: HOUSTON TX |
| COMMODITY: | ORIGIN: | DESTINATION: |
| HM CATEGORY CODE RQ? HW? | R, "" | ALLEGED SPEED |
| BULK 9S | SPEC, TANK AX 1 AX 2 AX 3 AX 4 AX 5 | AX 6 AX 7 AX 8 |
| | SPEC. TANK | RADAR CAL. |
| TICKET VIOL. CITE # Unit COS COS POST | VIOLATIONS DISC | OVERED |
| No. Y/N DISP ACC | DRIVER: PLEASE COMPLY WITH DIRECTIONS ON BA | CK SIDE OF THIS FORM |
| 1 FAIL T | DISPLAY LICENSE RECEIPT (COMMERCIAL MOTOR | VEHICLE) - |
| <u></u> | | |
| | | |
| | | |
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| | | |
| | VEHICLE (DDIVED OUT OF DEDVICE NOTICE | |
| VEHICLE Pursuant to authority contained in TRC Cha | /EHICLE/DRIVER OUT OF SERVICE NOTICE | o authority contained in OOS DISPOSITIONS |
| of Service" the vehicle/s with defects followed by column of this report. No person shall remove the | "YES" in the Out of Service TRC Chapter 644 i | hereby notify and A. Repaired at Scene / Obtained Oper. Auth. |
| applied to these vehicles or operate such vehicles defects have been repaired and the vehicles have b | until the out of service Out of Service, Nen restored to safe operating permit or require | lo motor carrier shall B. Towed/Escorted to driver to drive or Repair Service |
| condition, or proper operating authority has been see CONTINUATION SHEET TROOPER COMMENTS: | operate any motor | U. Unknown |
| DRUG TEST-YES | | N. Driver OOS |
| UNIT 1 VIN | Y | |
| | COPY RECEIVE | ✓ Log Book Exemption |
| INSPECTED BY: ID/REGION/ | ISTRICT/AREA TIME COMPLETED REPORT PREPARED | |
| LENNOX, RICHARD 28-026 | 682 2 9 8 7:35AM REFERRAL ID | |
| CHARGES FILED BY: | BRAKES INSPECTE | D BY: 28-026682 |

ANY ENTRIES IN THE VIOLATIONS' SECTION OF DRIVER'S COPY, WHERE THERE IS "YES" IN THE TICKET BOX, INDICATES CHARGES FILED AGAINST THE DRIVER. THIS WILL REQUIRE CONTACTING THE JUDGE FOR APPROPRIATE DISPOSITION.

JUDGE INFORMATION IS IN HEAVY BORDER BOX ON DRIVER'S COPY

PAYMENTS FOR FINES SHOULD BE SENT TO THE COURT LISTED ON THE DRIVERS COPY.

DO NOT SEND PAYMENTS TO TX DPS/MCB.

| | CERTIFICATE OF REPAIRM | IAN | |
|--|---|----------------|----------------------|
| I CERTIFY THAT THE REQUIRED I OF THIS CERTIFICATE HAVE BEEN | REPAIRS SHOWN IN THE "OUT OF SATISFACTORILY COMPLETED. | SERVICE" COLUN | IN ON THE OTHER SIDE |
| SIGNATURE OF REPAIRMAN: | TURE OF REPAIRMAN: NAME OF SHOP (GARAGE): REPAIR WO | | WORK COMPLETED: |
| | | DATE: | TIME: |
| CERTIFY THAT ALL VIOLATIONS | OR CARRIER CERTIFICATION OF AC NOTED UPON THIS REPORT HAN LIANCE WITH THE MOTOR CARRIE CARRIERS AND DRIVERS. | E BEEN CORRE | |
| SIGNATUREOF CARRIER OFFICIAL: | TITLE: HSF Manager | DATE: | 9-20D |

ATTENTION DRIVER:

This report must be furnished to the motor carrier whose name appears on this report.

ATTENTION DRIVER:

TRC Chapter 644, Revised Statutes, requires the Motor Carrier to execute the above

certification and return this report to:

MOTOR CARRIER SAFETY SECTION TEXAS DEPARTMENT OF PUBLIC SAFETY PO BOX 4087

AUSTIN TX 78773-0521

IMPORTANT MESSAGES

Any enforcement actions taken against you and any subsequent court actions are intended to secure compliance with the traffic laws and all other users of the highways. Failure to comply with your written promise to appear in court as made on this citation will constitute a separate offense with which you may be charged and result in warrants being issued for your arrest. Failure to appear in court or failure to satisfy a judgment ordering the payment of a fine and cost in the manner ordered by the court may result in the denial of renewal of your driver's license.

A second or subsequent conviction of failure to maintain financial responsibility will result in the suspension of your driver's license and motor vehicle registration unless you file and maintain proof of financial responsibility with the Department of Public Safety for two (2) years from the date of conviction. The Department may waive the requirement to file proof of financial responsibility if you file satisfactory evidence with the Department showing that at the time this citation was issued, the vehicle was covered by a liability insurance policy or that you were otherwise exempt from the requirements to provide evidence of financial responsibility.

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PB-019-(08/05)

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| TX076G0DBZ02 | HOUSTON BOLLOF BEDAL | | LEVE |
|--|---|--|---|
| | HOUSTON POLICE DEPAIRS. FOR HIRE FOR HIRE | CP#: | 0151818 |
| ☐ ACCIDENT ☐ 16 PASS. ☐ CDL ☐ SCHEDULE | NOT FOR HIRE SP PROG. DV INDEDCEMENT | ONSTRUCTION ZONE FIXED YES NO SCALE OCCUPIED HOUSE | ✓ ROADSIDE ALCH DS |
| DATE: 08/20/2007 | | HWY: (5) 9505 WALLIS | |
| LESSEE/MC: C E S ENVIROMENTAL | | | USDOT#: 0869392 |
| ADD/CITY/ST/ZIP: 4904 GRIGGS | RD (3901 TRAILMOBILE) HOUSTON TX 77013 | | ICC/MC#: 400234 |
| OWNER: STEVEN K STRICKER | | | TXDOT#: 005516524C |
| ADD/CITY/ST/ZIP: (b) (4) | | | PHONE#: 7136761460 |
| OPERATOR: BOBBY RODRIGUES | RACE/SEX: | : нм ров. (b) (4) | MED CARD: 8/7/08 |
| ADD/CITY/ST/ZIP: (D) (4) | A | DI. #: (b) (4) | ST: TX DL CLASS: A |
| VEH SEARCH: YES NO | REASON FOR STOP: WARN CITATION | ☐INSPECTION CONTRABAN | D LOCATED: TYES NO |
| THE OF SEARCH: CONSENT | | THE AMERICAN AND AND ADDRESS OF THE AMERICAN AND ADDRESS OF THE AD | APONS CURRENCY OTHER |
| X SIGNATURE: | UNIT TYPE MAKE COA 1 TT PTRB 282 2 ST PINE 230 | (b) (4) TX | |
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| PHONE: ON | N/BEFORE AT | PERMIT #: | |
| ADDRESS: TX | | RG WT #1 80000 RG WT #2 | GVWR #1 |
| SEAL #'S REMOVED: DEPT. | SEAL #; INSTALLED CVSA DECAL-TT C | VSA DECAL-ST CVSA DECAL | GVWR #2 |
| | | 706108 | -51 |
| SHIPPING #: 002168045 | CONSIGNOR: | Anna a anna anna anna anna anna anna an | |
| CHEMICALS | HOUSTON | CONSIGNEE: | MILLINGTON TN |
| COMMODITY: HM CATEGORY | ORIGIN: | DESTINATION: | |
| NON BULK | R | /4 1 1/2 1 1/2 | ALLEGED SPEED |
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| į. | 3 D D 3FEC. 14NK L 1 1 1/2 1 3/ | /4 1 1/2 1 1/2 | RADAR CAL. |
| FICKET VIOL. CITE # Unit OOS O | OS !POST \ VII | DLATIONS DISCOVERED | |
| No. Y/N Di | SP ACC DRIVER:PLEASE COMPLY WITH DIRE | | S FORM |
| 393.11 1 | INOPERABLE TAIL LAMP - INSIDE EDGE | | |
| 393.19 1 | DEFECTIVE TURN SIGNAL LAMP (#) - LEFT | SIDE | |
| 393.25(f) 1 | DEFECTIVE STOP LAMP (#) ~ LEFT SIDE | | |
| 393.75(c) 1 | FIRE LESS THAN 2/32 OF AN INCH - LEFT | SIDE | |
| 393.75(b) 1 | FRONT TIRE LESS THAN 4/32 OF AN INCH - | 3RD LEFT INSIDE | |
| | | | |
| | VEHICLE/DRIVER OUT OF SERVICE | | |
| of Service" the vehicle/s with defe column of this report. No person s applied to these vehicles or operat | shall remove the out of service stickers dec desuch vehicles until the out of service Out vehicles have been restored to safe operating per | The rurement to authority con- chapter 644 I hereby hotify a clare the driver named on this: of Service. No motor carrier mit or require driver to drive rate any motor vehicle until | nd A. Repaired at Scene / report Obtained Oper. Auth. shall B. Towed/Escorted to or Repair Service D. Other U. Unknown |
| /A TESTING YES VIN# (b) (4) | | 10 - | N. Driver OOS |
| | <u>X</u> | NONY PROPERTY. 57 | Log Book Exemption |
| NSPECTED BY: | ID/REGION/DISTRICT/AREA TIME COMPLETED REPO | COPY RECEIVED BY DRT PREPARED BY: BAYNES, | TIMOTHY D |
| AYNES, TIMOTHY D | · · · · · · · · · · · · · · · · · · · | | , BARRY E. |
| ARGES FILED BY: | BRAK | ES INSPECTED BY: 2V-07852 | 3 |

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ATTENTION DRIVER: TRC Chapter 644, Revised Statutes, requires the Motor Carrier to execute the below

certification and return this report to: MOTOR CARRIER SAFETY SECTION

TEXAS DEPARTMENT OF PUBLIC SAFETY
PO BOX 4087

AUSTIN TX 78773-0521

| CERTIFICATION OF REPAIRMAN I CERTIFY THAT THE REQUIRED REPAIRS SHOWN IN THE "OUT OF SERVICE" COLUMN ON THE OTHER SIDE OF THIS CERTIFICATE HAVE BEEN SATISFACTORILY COMPLETED. | | | | |
|--|------------------------|-----------------------|--|--|
| SIGNATURE OF REPAIRMAN: | NAME OF SHOP (GARAGE): | REPAIR WORK COMPLETED | | |

| TO ASSURE COMPLIANCE WITH THE MOTOR CARRIERS AND DRIVERS. | | | | |
|---|---------------|---------|------------------|--|
| SIGNATURE OF CARRIER OFFICAL: | TITLE: HSE | Manager | DATE: 8-21-07 | |

MOTOR CARRIER CERTIFICATION OF ACTION TAKEN

IMPORTANT MESSAGES

Any enforcement actions taken against you and any subsequent court actions are intended to secure compliance with the traffic laws and all other users of the highways. Failure to comply with your written promise to appear in court as made on this citation will constitute a separate offense with which you may be charged and result in warrants being issued for your arrest. The issuance of arrest warrants will make you subject to entry into the wanted persons file of this department. Failure to appear in court or failure to satisfy a judgement ordering payment of a fine and cost in the manner ordered by the court may result in the denial of renewal of your driver's license.

You may be able to require that this charge (Violations of Chapter 545, Transportation Code - Operation and Movement of Vehicles) be dismissed by taking a driving safety course. However, you will lose that right if you do not provide written notice to the court on or before your appearance date of your desire to do so.

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| nd Job (for customer ige only) |
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Total Cost to Complete Work \$ 785

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| ✓ ARREST TKT ☐ 9 - 15 PASS. FOR HIRE ✓ COM. VEH. ☐ 16 PASS. FOR HIRE ☐ ACCIDENT ☐ 16 PASS. NOT FOR HIRE ☐ CDL ☐ SCHEDULE ☐ CHARTER | on acco. | TRUCTION ZONE YES 🗹 NO | ☑FIXED ☐ROADS SCALE HOUSE 3A304 | |
| | 34 AM COUNTY: JACKSON | | | |
| | SA AM COUNTY, DACASON | RW1: (2) 05-0 | | |
| LESSEE/MC: | | | USDOT | |
| ADD/CITY/ST/ZIP: | | | 1CC/M | |
| OWNER: C E S ENVIROMENTAL SERVICES | | | TXDOT | #: 005516524C |
| ADD/CITY/ST/ZIP: 4904 GRIGGS RD (3901 TRAIL | | <u> </u> | PHONE | #: 7136761460 |
| OPERATOR: LUIS EMANUEL RESENDEZ | RACE/SEX: | HM DOB: | MED C | ARD: |
| ADD/CITY/ST/ZIP: (0) (4) | <u>.</u> | DL #: (D) (4) | ST: T | X DL CLASS: A |
| VEH SEARCH: YES MO REASON FOR | STOP: WARN CITATION C | INSPECTION C | ONTRABAND LOCATED | : YES NO |
| TYPE OF SEARCH: CONSENT PC INC. TO | ARREST INVENTORY TYPE OF CON | TRABAND: DRUG | s | CURRENCY DOTHER |
| | UNIT TYPE MAKE CO# | | SI | |
| X h xpf | 1 TR CHEV 107 2 ST OTHR 222 | (b) (4) | TX TX | |
| SIGNATURE: | | | • | |
| I HEREBY PROMISE TO APPEAR AT THE TIME AND PLACE DESIGNATED IN THIS NOTICE. (THIS IS NOT A PLEA OF GUILTY) | x-0xx | | | |
| COPY RECEIVED BY | GROSS WEIGHT: | GROUP W | EIGHT: | |
| YOU ARE HEREBY NOTIFIED TO APPEAR | | LOAD DISP | ; | |
| JUDGE: R W BOBBY DOELITSCH COURT: JP | PCT./PLACE: 1/0 | PERMIT #: | | |
| PHONE: (361) 782-5259 ON/BEFORE 27-J | ru1-2007) AT 10:0 | OOAM RG WT #1 | | WR #1 17500 |
| ADDRESS: 411 N WELLS RM 302 EDNA TX 77957 | | | | WR #2 |
| | | | | |
| | ALLED CVSA DECAL-TT CVS | | | |
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| SEAL #'S REMOVED: DEPT. SEAL #; INSTA SHIPPING #: COMMODITY: 1500 GAL TANK W/STAND HM CATEGORY CODE RQ? HW? | CONSIGNOR: CES ENVIRONMENTAL SERVICES HOUSTON PLACARDS REQ? | CONSI | SA DECAL-ST GNEE: CES ENV SERVICE NATION: PORT LA | IRONMENTAL S |
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| SEAL #'S REMOVED: DEPT. SEAL #; INSTA SHIPPING #: COMMODITY: 1500 GAL TANK W/STAND HM CATEGORY CODE RQ? HW? NA TICKET VIOL. CITE # Unit OOS Y/ OOS POST NO. N DISP ACC | CONSIGNOR: CES ENVIRONMENTAL SERVICES ORIGIN: HOUSTON PLACARDS REQ? R SPEC. TANK L AX 1 AX 2 AX 3 | CONSI TX DESTI AX 4 AX 5 AX 6 ATIONS DISCOVER FIONS ON BACK SI | GNEE: CES ENV SERVICE NATION: PORT LA ALLEGI SPEED CE OF THIS FORM | IRONMENTAL S VACA TX ED SPEED LIMIT CAL. |
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| SEAL #'S REMOVED: DEPT. SEAL #; INSTA SHIPPING #: COMMODITY: 1500 GAL TANK W/STAND HM CATEGORY CODE RQ? HW? NA TICKET VIOL. CITE # Unit OOS Y/ OOS POST NO. N DISP ACC Yes 396.17(c) 2 EXPIRE Yes 393.95(f) 1 DEFECT | CONSIGNOR: CES ENVIRONMENTAL SERVICES ORIGIN: HOUSTON PLACARDS REQ? R SPEC. TANK AX 1 AX 2 AX 3 L VIOL DRIVER: PLEASE COMPLY WITH DIRECT ED CMV INSPECTION CERTIFICATE TIVE/IMPROPER WARNING DEVICE | CONSI TX DESTI AX 4 AX 5 AX 6 ATIONS DISCOVER FIONS ON BACK SII ANNUAL DOT NO WARNING DE | GNEE: CES ENV SERVICE NATION: PORT LA SPEED AX 7 AX 8 RADAR ED E OF THIS FORM VICE | IRONMENTAL S VACA TX ED SPEED LIMIT CAL. |
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ANY ENTRIES IN THE VIOLATIONS' SECTION OF DRIVER'S COPY, WHERE THERE IS "YES" IN THE TICKET BOX, INDICATES CHARGES FILED AGAINST THE DRIVER. THIS WILL REQUIRE CONTACTING THE JUDGE FOR APPROPRIATE DISPOSITION.

JUDGE INFORMATION IS IN HEAVY BORDERED BOX ON DRIVER'S COPY.

PAYMENTS FOR FINES SHOULD BE SENT TO THE COURT LISTED ON THE DRIVER'S COPY.

DO NOT SEND PAYMENTS TO TX DPS/MCB.

CERTIFICATION OF REPAIRMAN

I CERTIFY THAT THE REQUIRED REPAIRS SHOWN IN THE "OUT OF SERVICE" COLUMN ON THE OTHER SIDE OF THIS CERTIFICATE HAVE BEEN SATISFACTORILY COMPLETED.

SIGNATURE OF REPAIRMAN:

NAME OF SHOP (GARAGE):

REPAIR WORK COMPLETED

DATE:

TIME:

Am

980 OD

Ces

MOTOR CARRIER CERTIFICATION OF ACTION TAKEN

I CERTIFY THAT ALL VIOLATIONS NOTED UPON THIS REPORT HAVE BEEN CORRECTED AND ACTION HAS BEEN TAKEN TO ASSURE COMPLIANCE WITH THE MOTOR CARRIER SAFETY REGULATIONS INSOFAR AS THEY ARE APPLICABLE TO MOTOR CARRIERS AND DRIVERS.

SIGNATURE OF CARRIER OFFICIAL:

TITLE:

DATE

HSE Manager

7-12-07

ATTENTION DRIVER:

This report must be furnished to the motor carrier whose name appears on this report.

ATTENTION DRIVER:

TRC Chapter 644, Revised Statutes, requires the Motor Carrier to execute the above certification

and return this report to:

MOTOR CARRIER BUREAU TEXAS DEPARTMENT OF PUBLIC SAFETY

PO BOX 4087

AUSTIN TX 78773-0521

IMPORTANT MESSAGES

Any enforcement actions taken against you and any subsequent court actions are intended to secure compliance with the traffic laws and all other users of the highways. Failure to comply with your written promise to appear in court as made on this citation will constitute a separate offense with which you may be charged and result in warrants being issued for your arrest. Failure to appear in court or failure to satisfy a judgement ordering payment of a fine and cost in the manner ordered by the court may result in the denial of renewal of your driver's license.

"A second or subsequent conviction of failure to maintain financial responsibility will result in the suspension of your driver license and motor vehicle registration unless you file and maintain proof of financial responsibility with the Department of Public Safety for two (2) years from the date of conviction. The Department may waive the requirements to file proof of financial responsibility if you file satisfactory evidence with the Department showing that at the time this citation was issued the vehicle was covered by a liability insurance policy or that you were otherwise exempt from the requirements to provide evidence of financial responsibility.

You may be able to require that this charge be dismissed by successfully completing a driving safety course or a motorcycle operator training course. You will lose that right if, on or before your appearance date, you do not provide the court with notice of your request to take the course. This article does not apply to an offense committed by a person who holds a commercial driver's license.

"A conviction of an offense under a traffic law of this state or a political subdivision of this state may result in the assessment on your driver's license of a surcharge under the Driver Responsibility Program."

A request for an out-of-service review, regarding operating authority, must be made in writing and forwarded to the manager of the Motor Carrier Bureau. If requested, a review will be scheduled and conducted by the manager of the Motor Carrier Bureau or the director's designee within 10 days of the issuance of the out-of-service order. A request for review should be addressed to the Texas Department of Public Safety, Motor Carrier Bureau, P.O. Box 4087, Austin, TX 78773-0521 or may be sent by facsimile transmission to (512) 424-5712 or via electronic mail at MotorCarrierBureau@txdps.state.tx.us. The Department may conduct the review by telephone conference call.

To obtain a TxDOT Motor Carrier Insurance Certificate or Single State Registration - contact the Texas Department of Transportation at 1-800-299-1700 or visit their website at www.dot.state.tx.us.

To obtain a USDOT Number contact the Federal Motor Carrier Safety Administration at 1-800-832-5660 or visit their website at www.fmcsa.dot.gov/factsfigs/formspubs.htm.

To obtain IFTA information contact the State of Texas Comptrollers Office at 1-800-252-1383 or visit their website at www.window.state.tx.us/taxinfo/fuels/ifta.html.



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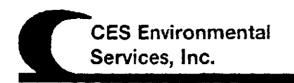
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| Total Cost to Complete Work \$62_50 | | | |



4904 Griggs Road Houston, TX 77021 Phone: (713) 676-1460 Fax: (713) 676-1676

| Fax To: Ms. Dora | From: | Prabhakar R Mobile: ^{(b) (4)} | . Thangudu | 7 |
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| Fax: 361-782-7039 | Pages: | | | |
| Phone: | Date: | 7-13-07 | | |
| ATTN: Ms | | | | |
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| LESSEE/MC: | USDOT#: 0869392 |
| ADD/CITY/ST/ZIP: | ICC/MC#: 400234 |
| OWNER: C E S ENVIROMENTAL SERVICES | TXDOT#: 005516524C |
| ADD/CITY/ST/ZIP: 4904 GRIGGS RD (3901 TRAILMOBILE) HOU | |
| OPERATOR: LUIS EMANUEL RESENDEZ | RACE/SEX: HM DOB: (b) (4) MED CARD: |
| ADD/CITY/ST/ZIP: (b) (4) | DL #: (b) (4) ST: TX DL CLASS: A |
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| GROSS WEI | GHT: / GROUP WEIGHT: |
| YOU ARE HEREBY NOTIFIED TO APPEAR | LOAD DISP: |
| JUDGE: R W BORBY DOELITSCE COURT: JP | PCT./PLACE: 1/0 PERMIT #: |
| PHONE: (361) 782-5259 ON/BEFORE 27-Jul-2007 | AT 10:00AM RG WT #1 44000 GVWR #1 17500 |
| ADDRESS: 411 N WELLS RM 302 EDNA TX 77957 | RG WT #2 0000 GVWR #2 |
| SEAL #'S REMOVED: DEPT. SEAL #; INSTALLED | CVSA DECAL-TT CVSA DECAL-ST CVSA DECAL-ST |
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| SHIPPING #: CONSIGNOR | CES ENVIRONMENTAL CONSIGNEE: CES ENVIRONMENTAL |
| 1500 GAL TANK W/STAND | SERVICES SERVICES |
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| HM CATEGORY CODE RQ? HW? PLACARDS E | REQ? R SPEED |
| HM CATEGORY CODE RQ? HW? PLACARDS F | REQ? R SPEED |
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| HM CATEGORY CODE RQ? HW? PLACARDS F NA SPEC. TR TICKET VIOL. CITE # Unit COOS Y COOS POST | REQ? R AX 1 AX 2 AX 3 AX 4 AX 5 AX 6 AX 7 AX 8 RADAR CAL. VIOLATIONS DISCOVERED |
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| TICKET VIOL. CITE # Unit COS Y COS POST DRIVER;PL Yes 96.17(q) 2 EXPIRED CMV INS Yes 393.95(f) 1 DEFECTIVE/IMPRO | REQ? R AX 1 AX 2 AX 3 AX 4 AX 5 AX 6 AX 7 AX 8 RADAR CAL. VIOLATIONS DISCOVERED LEASE COMPLY WITH DIRECTIONS ON BACK SIDE OF THIS FORM SPECTION CERTIFICATE / ANNUAL DOT - NO INSPECTION |
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| TICKET VIOL. CITE # Unit OOS Y OOS POST TICKET VIOL. CITE # Unit OOS Y OOS POST Yes 196.17(a) 2 EXPIRED CMV INS 1 DEFECTIVE/IMPRO 1 FAIL TO DISPLAY L VEHICLE Pursuant to authority contained in TRC Chapter 644 I he of Service" the vehicle's with defects followed by "YES" in the column of this report. No person shall remove the out of service applied to these vehicles or operate such vehicles until the out defects have been repaired and the vehicles have been restored condition, or proper operating authority has been obtained. SEE CONTINUATION SHEET TROOPER COMMENTS: #IVIN 10 (4) 2VIN: 10 TRAILER HAS NO CMV INSPECTION | REQ? R AX 1 AX 2 AX 3 AX 4 AX 5 AX 6 AX 7 AX 8 RADAR CAL. VIOLATIONS DISCOVERED LEASE COMPLY WITH DIRECTIONS ON BACK SIDE OF THIS FORM SPECTION CERTIFICATE / ANNUAL DOT - NO INSPECTION OPER WARNING DEVICE - NO WARNING DEVICE STEEDY declars "Out of Service constituted and the s |
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| TICKET VIOL. CITE # Unit COS Y OOS POST NO. NO DISP ACC DRIVER:PL Yes 96.17(g) 2 EXPIRED CMV INS Yes 393.95(f) 1 DEFECTIVE/IMPRO 1 FAIL TO DISPLAY L VEHICLE Pursuant to authority contained in TRC Chapter 644 I he column of this report. No person shall remove the out of servi applied to these vehicles or operate such vehicles until the outer defects have been repaired and the vehicles have been restored condition, or proper operating authority has been obtained. SEE CONTINUATION SHEET TROOPER COMMENTS: #IVIN 10 20 TRAILER HAS NO CMV INSPECTION NO EMERGENCY WARNING DEVICE | REQ? R REQ? R AX 1 AX 2 AX 3 AX 4 AX 5 AX 6 AX 7 AX 8 RADAR CAL. VIOLATIONS DISCOVERED EASE COMPLY WITH DIRECTIONS ON BACK SIDE OF THIS FORM SPECTION CERTIFICATE / ANNUAL DOT - NO INSPECTION OPER WARNING DEVICE - NO WARNING DEVICE Freby declare "Out of Service constituted in the service constituted in the service constituted in the service to safe operating of service. No motor carrier shall permit or require driver to drive or operate any motor vehicle until TRUCK BACK STATE OF THIS FORM OUT OF SERVICE NOTICE TRUCK STATE OF THIS FORM OUT OF SERVICE NOTICE TRUCK STATE OF THIS FORM AND IN SPECTION OUT OF SERVICE NOTICE TRUCK STATE OF THIS FORM OUT OF SERVICE NOTICE TRUCK STATE OF THIS FORM AND IN SPECTION AREA OF THIS FORM OUT OF SERVICE NOTICE TRUCK STATE OF THIS FORM AREA OF THIS FORM OUT OF SERVICE NOTICE TRUCK STATE OF THIS FORM AREA OF THIS FORM OUT OF SERVICE NOTICE TRUCK STATE OF THIS FORM OUT OF SERVICE NOTICE TRUCK STATE OF THIS FORM OUT OF SERVICE NOTICE OUT OF SERVICE NOTICE OUT OF SERVICE NOTICE TRUCK STATE OF THIS FORM AREA OF THIS FORM OUT OF SERVICE NOTICE TRUCK STATE OF THIS FORM OUT OF SERVICE NOTICE OUT OF SERVICE NOTICE OUT OF SERVICE NOTICE TRUCK STATE OF THIS FORM AREA OF THIS FORM OUT OF SERVICE NOTICE TRUCK STATE OF THIS FORM OUT OF SERVICE NOTICE TRUCK STATE OF THIS FORM OUT OF SERVICE NOTICE OUT OF SERVICE NOTICE TRUCK STATE OF THIS FORM OUT OF SERVICE NOTICE TRUCK STATE OF THIS FORM OUT OF SERVICE NOTICE TRUCK STATE OF THIS FORM OUT OF SERVICE NOTICE TRUCK STATE OF THIS FORM AREA OF THIS FORM OUT OF SERVICE NOTICE TRUCK STATE OF THIS FORM OUT OF SERVICE NOTICE TRUCK STATE OF THIS FORM OUT OF SERVICE NOTICE TRUCK STATE OF THIS FORM OUT OF SERVICE NOTICE TRUCK STATE OF THIS FORM OUT OF SERVICE NOTICE TRUCK STATE OF THIS FORM OUT OF SERVICE NOTICE TRUCK STATE OF THIS FORM OUT OF SERVICE NOTICE TRUCK STATE OF THIS FORM OUT OF SERVICE NOTICE OUT OF SERVICE NOTICE OUT OF SERVICE NOTICE OUT OF SERVICE NOTICE OUT OF SERVI |

202

202 FBT

Active

Drum Trailer

17YBP202XXB018614

97487Y TFI

1999

10/14/04

Trailers



Tire Size: 7 - 15LT; Empty wt.:2400;

| | PM | Preventive | Quarterly | Time | 0 | 0 | 0 | 0 | 10/06/05 | 01/06/06 | #Name? |
|-----|--------|----------------|-----------|------|---|---|---|---|----------|----------|--------|
| | Brakes | brakes | Quarterly | Time | 0 | 0 | 0 | 0 | 10/14/04 | 01/14/05 | #Name? |
| K | DOT | DOT Inspection | Annual | Time | 0 | 0 | 0 | 0 | 01/19/07 | 01/19/08 | #Name? |
| , 0 | PEG | Registration | Annual | Time | 0 | 0 | 0 | 0 | 09/01/06 | 09/01/07 | #Name? |

Miss Doza:

- 1) Trailer with license plate was ticketed for Dot inspection.
 (2) This trailer was inspected on 1-19-07 and due for inspection on 1-19-08.
- 3 Would you be able to waive the penalty on this?

EPAHO042001315

Ms. Dosa:

Here is a copy of the barcode of DOT inspection for trailer with license plate 97487 Y



******** - IND. XMT JOURNAL- ********** DATE JUL-13-2007 ***** TIME 12:32 ********

DATE/TIME = JUL-13-2007 12:30

JOURNAL No. = 057

COMM. RESULT = OK

PAGE(S)

= 004

DURATION = 00:01:43

FILE No.

= 383

MODE

= MEMORY TRANSMISSION

DESTINATION = 13617827039

RECEIVED ID

= / 3617827039

RESOLUTION

= STD

-CES Environmental Svcs. -

***** DP-3030 ***************

7137488664- *******

| | cket# 6 | 75308 | \rightarrow | | ~1*X | 097 | 2016 _{CVE} | -3 (Rev. 12/03) |
|---|---------------------|---|-------------------------------------|-------------------------|------------------|------------|----------------------|--|
| TX076D0DBJ01 | BAYTO | WN POLICE DE | PARTMENT | | CD ₁ | ι. Λ· | 15101 | LEVEL |
| ☑ ARREST TKT ☐ 9 - 15 PASS. FOR HIR | ∑ | Cov | A Lymal | ZW. | CPH | F : U. | 15181 | 0 1 |
| ☐ COM. VEH. ☐ 16 PASS. FOR HIRE ☐ ACCIDENT ☐ 16 PASS. NOT FOR HIR | an proc. | ✓ INTERSTAT | CONSTRUCTI | ON ZOR | NE 🗀F | XED V | T ROADSIDE | ☐ ALCH ☐ DS |
| ☐ ACCIDENT ☐ 16 PASS. NOT FOR HIR ☐ CDL ☐ SCHEDULE ☐ CHARTER | | ✓ INTERSTAT | ☐ IES | ☑ NO. | SCA HOU | ALE ISE | | □ NEST □ ES |
| DATE: 08/17/2007 TIME: | 9:00 AM COUNTY | _ | _ | | | | | м,₽,#; 483 |
| LESSEE/MC: C E S ENVIROMENTAL SERVICES | · | | | 3=2- | | | USDOT#: | 0869392 |
| ADD/CITY/ST/ZIP: 4904 GRIGGS RD (3901 T | RAILMOBILE) HOUS | TON TX 77013 | | | | | ICC/MC#: | 400234 |
| OWNER: STEVEN K STRICKER | | | | | | | TXDOT#: | 005516524C |
| ADD/CITY/ST/ZIP: 957 MILL RD ANGLETON T | к 77515 | | | | | | PHONE#: | 7136761460 |
| OPERATOR: ROBERT JOE HICKMAN | | RACE | SEX: EM | DOB: | (b) (4) | | MED CARD: | 08/03/2007 |
| ADD/CITY/ST/ZIP: (b) (4) | | | DI | #: (| o) (4) | | ST: TX | DL CLASS: A |
| VEH SEARCH: ☐ YES ☑ NO REASON F | OR STOP: WAR | N CITATIO | n ∐INSP | ECTION | CONT | RABAND I | LOCATED: |]yes □no |
| TYPE OF SEARCH: CONSENT PC INC. | TO ARREST IN | ENTORY TYPE | OF CONTRABA | ND: | DRUGS | □WEAP(| ons □curre | NCY OTHER |
| | UNIT TYPE | MAKE | CO# | ELATI | ST. | 1 . | | |
| | 1 1 | PTRB | 281 | 0) (4) | TX | 1 | 3 | |
| Voat 1'h | 2 ST | HEIL | 210 | | TX | | | |
| 1 Kolon Breken | | | _ | | C. | B1 11 11 | | o s63 |
| SIGNATURE: | | | | M | | رمين | whee 0:0 | 0 53 ³⁵ -086 ³ |
| I HEREBY PROMISE TO APPEAR AT THE TIME PLACE DESIGNATED IN THIS NOTICE. (THIS | 1S | | . 6 | X Y | - N. Dev | as V | John of | |
| NOT A PLEA OF GUILTY; | x00 | -00 | ر کی ر | CU | 60 × 11 | , | 180 | , |
| COPY RECEIVED BY | GROSS WEIG | HT: | VQ. | GRE | OD MEIC | HT: | U) | |
| YOU ARE HEREBY NOTIFIED TO APPEAR | | 9 | | LOAD | DISP: | | | |
| JUDGE: Julie Escalante | OURT: Municipal | PCT./PLA | CE: 071 | PERM | IT #: | ÷ | ·····- | |
| PHONE: (281) 427-9511 N/BEFORE 02 | 2-oct-2007 | AT | 9:00AM | BG W | r #1 80 | ,000 | GVWR #: | |
| ADDRESS: 3120 N MAIN ST BAYTOWN TX 77521 | | | | RG W | г #2 о | | GVWR #2 | 2 |
| SEAL #'S REMOVED: DEPT. SEAL #; I | NSTALLED | CVSA DECAL-TT | CVSA DEC | AL-ST | CVSA | DECAL-S | T | |
| 002160384 | : | CES ENVIRON | materna v | | | | OLTEX | |
| SHIPPING #: | CONSIGNOR: | CES ENVIROR | ENIAL | | CONSIGNE | E: | /LIEA | |
| COMMODITY: WASTE FLAMM LIQ NOS | ORIGIN: | BEAUMONT | | TX | DESTINAT | ION: | APORTE | TX |
| HM CATEGORY CODE RQ? | HW? PLACARDS RE | Q? 1 11 | 2 1 5/8 1 5/8 | 1 1/2 | | 1 | ALLEGED SPI | EED |
| BULK 3 | | | 2 7 2 7 4 | 7V E | 10 C 20 | 7 7 7 9 | SPEED LIMI | r l |
| | SPEC. TAN | 1 11 | 2 AX 3 AX 4 2 1 3/8 1 3/4 | 4 | | I AA a | RADAR CAL. | |
| | | L | | | | - | | - |
| TICKST VIOL. CITE # Unit OOS OOS POST No. 1/N DISP ACC | DRIVER:PLE | ASE COMPLY WITH | VIOLATIONS DIRECTIONS | | | OF THIS | FORM | |
| Yes 398.43(a) 1 Yes D IM | PROPER TRACTOR | | | | | | | DROP TO 0 |
| 172.328D 2 FA | LURE TO PROPERL | MARK MANUAL I | EMOTE SHUTO | FF DEV | ICE - NO | NE | | |
| 393,45(D) 2 BB | ARE CONNECTIONS I | TERRET TERRE / COM | TRICTIONS - | TUNE | CEDITA | ETND CT1 | | |
| 393.45(D) 2 | THE CONNECTIONS | VIII LEARS/CONS | | LEAR | SERVICE . | SIDE GIR | D BAND | |
| 391.45 (b) D EX | PIRED MEDICAL EX | MINERS CERTIF | CATE - 9/03, | /2007 | | | | |
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| _ R+ | | ER OUT OF SE | DRIVER PUR | | an marketa and e | | TOUTH SOUTH NAMED IN | |
| ▼ VEHICLE Pursuant to authority contained in TRC of Service" the vehicle/s with defects followe column of this report. No person shall remove | a by "YES" in the C | ut of Service | TRC Chapte | : D44 . | r nereby n | orrry and | 1 A. K | DISPOSITIONS epaired at Scene / ined Oper, Auth. |
| applied to these vehicles or operate such vehicles have been repaired and the vehicles ha | cles until the out | of service | Out of Ser permit or | vice. 1 | No motor c | arrier si | all B. To | owed/Escorted to Ir Service |
| condition, or proper operating authority has b SEE CONTINUATION SHEET TROOPER COMMENT | een obtained. | 9 | operate an | | | | D. 01 U. Ut | her known |
| CLASS A DCL REST: NONE; END: TX; HONE | ; D/A TESTI | | | | | <u></u> | | river OOS |
| INSPECTED 4200 BLK N HWY 146 S/B; VIN | RED TAGGED ESC | ORTED TO | Yale | 1.1 | | د. | <u> </u> | |
| | _ | | 1/4 bi | <u>^ K</u> | Wen. | | L | og Book Exemption |
| INSPECTED BY: ID/REGI | ON/DISTRICT/AREA | TIME COMPLETE | | ECEIVE EPAREI | | VIS, KE | VIN E | |
| | -001657 2 9 Z | 9:50AM | REFERRAL | | | NEK, DA | | |
| CHARGES FILED BY: DAVIS, KEVIN E 2Z-00 | | | BRAKES IN | | | | | |

ANY ENTRIES IN THE VIOLATIONS' SECTION OF DRIVER'S COPY, WHERE THERE IS "YES" IN THE TICKET BOX, INDICATES CHARGES FILED AGAINST THE DRIVER. THIS WILL REQUIRE CONTACTING THE JUDGE FOR APPROPRIATE DISPOSITION.

JUDGE INFORMATION IS IN HEAVY BORDERED BOX ON DRIVER'S COPY.

PAYMENTS FOR FINES SHOULD BE SENT TO THE COURT LISTED ON THE DRIVER'S COPY.

DO NOT SEND PAYMENTS TO TX DPS/MCB.

| CERTIFICATION OF REPAIRMAN | | | | | | | |
|--|---|-------------------------|----------------|--|--|--|--|
| I CERTIFY THAT THE REQUIRED REPAIRS SHOWN IN THE "OUT OF SERVICE" COLUMN ON THE OTHER SIDE | | | | | | | |
| OF THIS CERTIFICATE HAVE BEEN | SATISFACTORILY COMPLETED. | | | | | | |
| SIGNATURE OF REPAIRMAN: | NAME OF SHOP (GARAGE): | REPAIR WORK | COMPLETED . | | | | |
| 10 m | Ces | DATE: | TIME: | | | | |
| | Ce2 | 8-17-07 | 11.30 | | | | |
| | | | <u> </u> | | | | |
| | RRIER CERTIFICATION OF ACT | | ND ACTION HAD | | | | |
| | IOTED UPON THIS REPORT HAVE BE ANCE WITH THE MOTOR CARRIER S | | | | | | |
| THEY ARE APPLICABLE TO MOTOR | | ALETT RECOLATIO | INO INSOFAR AS | | | | |
| CIONATURE OF CARRIER OFFICIAL | TITLE | DATE. | | | | | |
| SIGNATURE OF CARRIER OFFICIAL: | TITLE: | DATE: | | | | | |
| Labhant/Layon | HSE Manage | 8-17-07 | | | | | |
| ATTENTION DRIVER: This report must | be furnished to the motor carrier whose name | appears on this report. | | | | | |

ATTENTION DRIVER:

TRC Chapter 644, Revised Statutes, requires the Motor Carrier to execute the above certification

MOTOR CARRIER BUREAU

TEXAS DEPARTMENT OF PUBLIC SAFETY PO BOX 4087

PO BOX 4087

AUSTIN TX 78773-0521

IMPORTANT MESSAGES

and return this report to:

Any enforcement actions taken against you and any subsequent court actions are intended to secure compliance with the traffic laws and all other users of the highways. Failure to comply with your written promise to appear in court as made on this citation will constitute a separate offense with which you may be charged and result in warrants being issued for your arrest. Failure to appear in court or failure to satisfy a judgement ordering payment of a line and cost in the manner ordered by the court may result in the denial of renewal of your driver's license.

"A second or subsequent conviction of failure to maintain financial responsibility will result in the suspension of your driver license and motor vehicle registration unless you file and maintain proof of financial responsibility with the Department of Public Safety for two (2) years from the date of conviction. The Department may waive the requirements to file proof of financial responsibility if you file satisfactory evidence with the Department showing that at the time this citation was issued the vehicle was covered by a liability insurance policy or that you were otherwise exempt from the requirements to provide evidence of financial responsibility.

You may be able to require that this charge be dismissed by successfully completing a driving safety course or a motorcycle operator training course. You will lose that right if, on or before your appearance date, you do not provide the court with notice of your request to take the course. This article does not apply to an offense committed by a person who holds a commercial driver's license.

"A conviction of an offense under a traffic law of this state or a political subdivision of this state may result in the assessment on your driver's license of a surcharge under the Driver Responsibility Program."

A request for an out-of-service review, regarding operating authority, must be made in writing and forwarded to the manager of the Motor Carrier Bureau. If requested, a review will be scheduled and conducted by the manager of the Motor Carrier Bureau or the director's designee within 10 days of the issuance of the out-of-service order. A request for review should be addressed to the Texas Department of Public Safety, Motor Carrier Bureau, P.O. Box 4087, Austin, TX 78773-0521 or may be sent by facsimile transmission to (512) 424-5712 or via electronic mail at <u>MotorCarrierBureau@txdps.state.tx.us.</u> The Department may conduct the review by telephone conference call.

To obtain a TxDOT Motor Carrier Insurance Certificate or Single State Registration - contact the Texas Department of Transportation at 1-800-299-1700 or visit their website at www.dot.state.tx.us.

To obtain a USDOT Number contact the Federal Motor Carrier Safety Administration at 1-800-832-5660 or visit their website at www.fmcse.dot.gov/factsfigs/formspubs.htm.

To obtain IFTA information contact the State of Texas Comptrollers Office at 1-800-252-1383 or visit their website at www.window.state.tx.us/taxinfo/fuels/ifta.html,



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White - Equipment and Maintenance Files

Total Cost to Complete Work \$_ 3 6 9.50

Goldenrod - Customer Service (If Applicable)

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|---|--|
| ✓ ARREST TKT □ 9 - 15 PASS. FOR HIRE ✓ COM. VEH. □ 16 PASS. FOR HIRE | CONSTRUCTION ZONE ☐FIXED ☑ROADSIDE |
| ☐ ACCIDENT ☐ 16 PASS. NOT FOR HIRE ☐ CHARTER | SP PROG: INTERSTATE YES NO SCALE INTERSTATE OCCUPIED HOUSE SW TE |
| | :43 AM COUNTY: ORANGE HWY: (2) SH-0073 IN ORANGE CO. (776- M.P.#: 782 |
| LESSEE/MC: ADD/CITY/ST/ZIP: | USDOT#: 0869392 ICC/MC#: 400234 |
| OWNER: C E S ENVIROMENTAL SERVICES | TXDOT#: 005516524C |
| ADD/CITY/ST/ZIP: 4904 GRIGGS RD (3901 TRAI | (6) (4) |
| OPERATOR: WILLIAM BRADSHAW WOOD ADD/CITY/ST/ZIP: (b) (4) | RACE/SEX: WM DOB: MED CARD: 07-05-09 DL # (b) (4) ST: TX DL CLASS: A |
| VEH SEARCH: ☐ YES ☑ NO REASON FOR | |
| TYPE OF SEARCH: CONSENT PC INC. TO | |
| | UNIT TYPE MAKE CO# PLATE ST. 1 TT PTRB 275 TX |
| X | 2 ST OTHR 262 |
| SIGNATURE: | Tall and the line of the line |
| I HEREBY PROMISE TO APPEAR AT THE TIME AND PLACE DESIGNATED IN THIS NOTICE. (THIS IS | · · · |
| NOT A PLEA OF GUILTY) | x 00 00 |
| ☑ COPY RECEIVED BY | GROSS WEIGHT: GROUP WEIGHT: |
| YOU ARE HEREBY NOTIFIED TO APPEAR JUDGE: Janice Menard COUF | LOAD DISP: RT: JP PCT./PLACE: 3/0 |
| PHONE: (409) 735-8133 ON/BEFORE 21-Se | PERMIT #: PERMIT PER |
| ADDRESS: P. O. BOX 1400 BRIDGE CITY TX 77611 | RG WT #2 0 GVWR #2 0 |
| SEAL #'S REMOVED: DEPT. SEAL #: INST. | ALLED CVSA DECAL-TT CVSA DECAL-ST CVSA DECAL-ST |
| SHIPPING #: 48254 | CONSIGNOR: KMTEX CONSIGNEE: INTERNATIONAL PAPER |
| COMMODITY: SODIUM HYDROXIDE | ORIGIN: PORT ARTHUR TX DESTINATION: PINEVILLE LA |
| | ? PLACARDS REQ? ALLEGED SPEED |
| NA | SPEC. TANK AX 1 AX 2 AX 3 AX 4 AX 5 AX 6 AX 7 AX 8 RADAR CAL. |
| | |
| TICKET VIOL. CITE # Unit OOS OOS POST No. Y/N DISP ACC | VIOLATIONS DISCOVERED DRIVER: PLEASE COMPLY WITH DIRECTIONS ON BACK SIDE OF THIS FORM |
| ies 2 | RED CMV INSPECTION CERTIFICATE / ANNUAL DOT - NONE 529.00 |
| 395.8(f)(1) b pury 8 | STATUS NOT CURRENT - SLEEPER 4:30AM |
| 393.95(a) 1 FIRE E | EXTINGUISHER VIOLATION - NOT SECURE |
| | VIOLATIONS DISCOVERED DRIVER:PLEASE COMPLY WITH DIRECTIONS ON BACK SIDE OF THIS FORM RED CMV INSPECTION CERTIFICATE / ANNUAL DOT - NONE STATUS NOT CURRENT - SLEEPER 4:30AM EXTINGUISHER VIOLATION - NOT SECURE VEHICLE/DRIVER OUT OF SERVICE NOTICE speter 644 I hereby declare "Out DEFIVER Pursuant to authority contained in Oos Dispositions (A. Repaired at Scene / |
| | VEHICLE/DRIVER OUT OF SERVICE NOTICE |
| VEHICLE Pursuant to authority contained in TRC Cha of Service" the vehicle/s with defects followed by column of this report. No person shall remove the applied to these vehicles or operate such vehicles defects have been repaired and the vehicles have be condition, or proper operating authority has been SEE CONTINUATION SHEET TROOPER COMMENTS: | s until the out of service Out of Service. No motor carrier shall B. Towed/Escorted to permit or require driver to drive or Repair Service |
| | Log Book Exemption |
| INSPECTED BY: ID/REGION/ | COPY RECEIVED BY DISTRICT/AREA TIME COMPLETED REPORT PREPARED BY: FIKES, RONNIE GLENN |
| FIKES, RONNIE GLENN 0455 CHARGES FILED BY: FIKES, RONNIE GLENN 045 | 3 2 A 05 7:57AM REFERRAL ID |

ANY ENTRIES IN THE VIOLATIONS' SECTION OF DRIVER'S COPY, WHERE THERE IS "YES" IN THE TICKET BOX, INDICATES CHARGES FILED AGAINST THE DRIVER. THIS WILL REQUIRE CONTACTING THE JUDGE FOR APPROPRIATE DISPOSITION.

JUDGE INFORMATION IS IN HEAVY BORDERED BOX ON DRIVER'S COPY.

PAYMENTS FOR FINES SHOULD BE SENT TO THE COURT LISTED ON THE DRIVER'S COPY.

DO NOT SEND PAYMENTS TO TX DPS/MCB.

CERTIFICATION OF REPAIRMAN

I CERTIFY THAT THE REQUIRED REPAIRS SHOWN IN THE "OUT OF SERVICE" COLUMN ON THE OTHER SIDE OF THIS CERTIFICATE HAVE BEEN SATISFACTORILY COMPLETED.

SIGNATURE OF REPAIRMAN: NAME OF SHOP (GARAGE):

REPAIR WORK COMPLETED

DATE:

TIME:

9-8-07

1 Pm

MOTOR CARRIER CERTIFICATION OF ACTION TAKEN

I CERTIFY THAT ALL VIOLATIONS NOTED UPON THIS REPORT HAVE BEEN CORRECTED AND ACTION HAS BEEN TAKEN TO ASSURE COMPLIANCE WITH THE MOTOR CARRIER SAFETY REGULATIONS INSOFAR AS THEY ARE APPLICABLE TO MOTOR CARRIERS AND DRIVERS.

SIGNATURE OF CARRIER OFFICIAL:

TITLE: HSE Manage DATE: 9-10-67

ATTENTION DRIVER:

This report must be furnished to the motor carrier whose name appears on this report.

ATTENTION DRIVER:

TRC Chapter 644, Revised Statutes, requires the Motor Carrier to execute the above certification

and return this report to: MOTOR CARRIER BUREAU

TEXAS DEPARTMENT OF PUBLIC SAFETY

PO BOX 4087

AUSTIN TX 78773-0521

IMPORTANT MESSAGES

Any enforcement actions taken against you and any subsequent court actions are intended to secure compliance with the traffic laws and all other users of the highways. Failure to comply with your written promise to appear in court as made on this citation will constitute a separate offense with which you may be charged and result in warrants being issued for your arrest. Failure to appear in court or failure to satisfy a judgement ordering payment of a fine and cost in the manner ordered by the court may result in the denial of renewal of your driver's license.

"A second or subsequent conviction of failure to maintain financial responsibility will result in the suspension of your driver license and motor vehicle registration unless you file and maintain proof of financial responsibility with the Department of Public Safety for two (2) years from the date of conviction. The Department may waive the requirements to file proof of financial responsibility if you file satisfactory evidence with the Department showing that at the time this citation was issued the vehicle was covered by a liability insurance policy or that you were otherwise exempt from the requirements to provide evidence of financial responsibility.

You may be able to require that this charge be dismissed by successfully completing a driving safety course or a motorcycle operator training course. You will lose that right if, on or before your appearance date, you do not provide the court with notice of your request to take the course. This article does not apply to an offense committed by a person who holds a commercial driver's license.

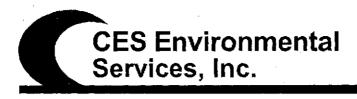
"A conviction of an offense under a traffic law of this state or a political subdivision of this state may result in the assessment on your driver's license of a surcharge under the Driver Responsibility Program."

A request for an out-of-service review, regarding operating authority, must be made in writing and forwarded to the manager of the Motor Carrier Bureau. If requested, a review will be scheduled and conducted by the manager of the Motor Carrier Bureau or the director's designee within 10 days of the issuance of the out-of-service order. A request for review should be addressed to the Texas Department of Public Safety, Motor Carrier Bureau, P.O. Box 4087, Austin, TX 78773-0521 or may be sent by facsimile transmission to (512) 424-5712 or via electronic mail at MotorCarrierBureau@txdps.state.tx.us.. The Department may conduct the review by telephone conference call.

To obtain a TxDOT Motor Carrier Insurance Certificate or Single State Registration - contact the Texas Department of Transportation at 1-800-299-1700 or visit their website at www.dot.state.tx.us.

To obtain a USDOT Number contact the Federal Motor Carrier Safety Administration at 1-800-832-5660 or visit their website at www.fmcsa.dot.gov/factsfigs/formspubs.htm.

To obtain IFTA information contact the State of Texas Comptrollers Office at 1-800-252-1383 or visit their website at www.window.state.tx.us/taxinfo/fuels/ifta.html.



| Date <u>09 - 08 - 09</u> | | |
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| Equipment Number or Description | CES Customer and | , |
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| otal Labor (hours x \$55.00) \$ <u>55</u> | | |
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Total Cost to Complete Work \$ 474.50

Certified Payments



Home

Begin a Payment

Support

Contact Us

Burea

Digital Receipt

Please print this page for your records. You will need this information if you need to contact the bureau for any reason regarding this payment.

| yment Information | | Transaction Inform | ation |
|----------------------|------------------------|---------------------|---|
| yment Type | Payment | Payment ID | 24277858 |
| yment Amount | \$219.00 | Auth. Response | 046702 |
| nvenience Fee Amount | \$8.76 | | |
| tal Amount | \$227.76 | | |
| formation | | Billing Information | |
| cket Number | 108941 | First Name | CES Environmenta |
| st Name | William | Middle Name | Sérvice In |
| idle Name | Bradshaw | Middle Name | |
| st Name | Wood | Last Name | CES Environmenta Service Ind |
| me Suffix | | Name Suffix | e man e e e e e e e e e e e e e e e e e e e |
| ephone | | Telephone | 713-676-1460 |
| dress | 4015 E. Undbergh Court | Address | 4904 Griggs Rd |
| y | BAYTOWN | City | NOTEVOH |
| te | Texas | State | Texas |
| ital Code | 77521 | ZIP Code | 77021 |
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| | | Print This Page | Return to Ma |

Addreas: 2376 W. Roundbunch Road P. O. Box 1400 Bridge City, TX 77611 Phone: (409) 735-8133 Fax: (409) 735-5197

Janice M. Menard, Pct. 3
Justice of the Peace

Fax

| To: Pra | uha Kar | | From: | Judge | Menar | d JP#3 |
|-------------|--------------|-------------|--------|------------|----------|------------------|
| Fax: 7/ | 3-676-16 | 76 | Pagés: | . 2 | ìnc | cover sheet |
| Phones | | · | Date: | 9-24 | -07 |) |
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| □ Urgent | ☐ For Review | □ Płease Co | mment | ☐ Piease R | leply | ☐ Please Recycle |
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The information contained in this facimile message is privileged and confidential information, intended only for the use of the Individual or entity named above. If the reader of this message is not the Intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this communication in error, please Immediately notify us by telephone, and return the original message to us at the above address via the U. S. Postal Service. Thank you.

CALL CONNIE, ALETA, OR DARYL AT (409) 735-8133 IN CASE OF FAILURE TO RECEIVE COMPLETE TRANSMISSION.

DRIVER/VEHICLE EXAMINATION REPORT OKLAHOMA HIGHWAY PATROL (TROOP S) Report Number: OK00!8060612 COMMERCIAL VEHICLE ENFORCEMENT 32 N.E. 23RD STREET Inspection Date: 09/24/2007 OKLAHOMA CITY, OK 73105-3002 Start Time: 11:15 AM End Time: 11:28 AM Phone: (405)521-6103 Fax: (405)521-6227 Insp. Level: 3-Driver/Credential, No HM Insp. CES ENVIRONMENTAL SERVICES INC DENBERG, DAVID F Driver: VA License#: 4904 GRIGGS ROAD State: TX HOUSTON, TX 77021 Date of Birth: USDOT#: 00869392 Phone#: (713)676-1460 CoDriver: MC/MX#: 400234 Fax#: License#: State: State#: Date of Birth: Location: US 75 AND CR 2400 MilePost: Shipper: SYSTECH ENVIRONMENTAL Highway: US 75 Origin: FREDONIA, KS Bill of Lading: 001396049FLE County: WASHINGTON, OK Destination: DEER PARK, TX Cargo: UN 1993 VEHICLE IDENTIFICATION CVSA# OOS# Unit Type Make Year License # Company # **GVWR** State 5 4 1 2000 296 54,000 1 TT **PTRB** TX ST OTHR 1995 257 68.000 2 TX BRAKE ADJUSTMENTS: No Brake Measurements Required For Level 3 **VIOLATIONS** Section Code Type Unit OOS Citation # Verify Crash Violations Discovered Expired medical examiner's certificate 391.45(b) D Ν Failure to obey traffic control device, when required - Haz Mat, fail to stop at D N Ν 392.2C R/R crossing. Placard: No Cargo Tank: HazMat: No HM Transported. Special Checks: Traffic Enforcement State Information:

WEIGHT GROSS: 40000; PORTABLE (SCALE TYPE): Yes; SEMI-PORTABLE: No; FIXED: No; WIM: No; AXLE (AXLE CONFIG. WEIGHED): No; TANDEM: No; BRIDGE: No; GROSS: Yes; INTERSTATE (ROAD TYPE): No; OFF INTERSTATE: Yes; TURNPIKE: No; LEGAL (WEIGHT ENF. ACTION): Yes; CITATION: No; WARNING: No; TANDEM (ARREST CONFIG.): No; AXLE: No; INNER BRIDGE: No; GRÒSS: No; OFF LOADED: No; ADJUSTED: No; PERMIT LOAD: No; O/W > OR = 2000 AXLE: No; O/W > OR = 5000 GROSS: No; DRIVER OOS?: No; VEHICLE OOS?: No; CIVIL PENALTY?: No; SHIPPER STREET ADDRESS: 1420 S CEMENT RD; SHIPPER CITY, STATE, ZIP: FREDONIA, KS 66736; VEHICLE OWNER NAME & DOT#: SAME AS MC;

NOTE TO DRIVER: This report must be furnished to the motor carrier whose name appears at the top of this report. NOTE TO CARRIER: If violations are noted, please ensure corrections are completed and sign the below certification. Please return the signed copy of this report within fifteen (15) days to the Oklahoma Highway Patrol, Troop S. Failure to comply may result in forfeiture of OCC License. Sen Date: Facility: CES Envisconnell Signature Of Repairer X:

**CARRIER CERTIFICATION: THE UNDERSIGNED CERTIFIES THAT ALL VIOLATIONS NOTED ON THIS REPORT HAVE BEEN CORRECTED AND ACTION HAS BEEN TAKEN TO ASSURE COMPLIANCE WITH THE OKLAHOMA MOTOR CARRIER SAFETY

STATUTES AS THEY ARE APPLICABLE TO MOTOR CARRIERS AND DRIVERS.

Signature Of Motor Carrier X:

Title:

Date: 9-

Report Prepared By: DARRIN ROSE

Badge #: 945

Copy Received By: DAVID VANDENBERG



| CONCENTRA Medical Centers | |
|-----------------------------|-----|
| MEDICAL EXAMINER'S CERTIFIC | ATE |

| l certify that I have examined 49 CFR 391.41-391.49 and with | A U.A. JANALA knowledge of the driving duties, | I find this person is qualified; ar | in accordance with FMCSR and, if applicable, only when: |
|---|--|-------------------------------------|---|
| Wearing Corrective Lenses | | Driving within an exempt | intracity zone (49 CFR 391.62) |
| Wearing Hearing Aid | | Accompanied by a Skill I | Performance Evaluation Certificate |
| Accompanied by a | waiver/exemption | Qualified by operation of | 49 CFR 391.64 |
| The information I have provided regard completely and correctly, and is on tile | ting this physical examination is true a .in my.office. | nd complete. A complete exam form | with any attachment embodies my findings |
| SIGNATURE OF MEDICAL EXAMINE | B | TELEPHONE ND. | PATE |
| MEDICAL EXAMINER'S NAME OF IN | | | MD □ DO □ Chiropractor □ Advanced |
| MEDICAL EXAMINER'S LICENSE OR CERTIFICATE ND. / ISSUING ST | TATE 184 | | Practice Nurse Physician's Assistant |
| SIGNATURE OF DRIVER | nes | (b) (4) | STATE |
| (b) (4) | and harries | ME | D. CERT, EXPIRATION DATE |

******** TIME 09:43 ****** DATE SEP-25-2007 **** TIME 09:43 ******

DATE/TIME

= SEP-25-2007 09:42

JOURNAL No.

COMM. RESULT = OK

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= 002

DURATION

= 00:00:28

FILE No.

= 356

MODE

= MEMORY TRANSMISSION

DESTINATION

= 14055216227

RECEIVED ID

= / 405 522 5932

RESOLUTION

-CES Environmental Svcs.

7137488664- *******

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| OWNER: C E S ENVIROMENTAL SERVICES | | | | | TXDOT#: | 005516524C |
| ADD/CITY/ST/ZIP: 4904 GRIGGS RD (3901 TRAI | LMOBILE) HOUSTON | TX 77013 | | The same of the sa | PHONE#: | 7136761460 |
| OPERATOR: NOAH DEAN BERRY | | RACE/SE | (: BM DOB: | (b) (4) | MED CARD: | 5-6-09 |
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| JUDGE: *Lorraine Lopez COUR | (T: JP | PCT./PLACE | 1/0 PERMIT | r#: † | , | |
| PHONE: • (361) 526-4877 ON/MEFORE 28-Se | p-2007 | AT | 10:00AM RG WT | #1 80,000 | GVWR #1 | |
| ADDRESS: 808 COMMERCE REFUGIO TX 18377 | 1 | | RG WT | #2 0 | GVWR #2 | 165,000 |
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| 1 0 | VEHICLE/DRIVER | | | A - | | |
| | VEHICLE/DRIVER | OUT OF SERV | ICE NOTICE | Suth or Ity contain | ined in 100s b | olspositions |
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| Column of this report. No person shall remove the applied to these vehicles or operate such vehicles defects have been repaired and the vehicles have been condition, or proper operating authority has been SEE CONTINUATION SHEET TROOPER COMMENTS: FLAMMABLE LIQUID NOS UN 1268 FG II (COKER GAS VIN #1 (D) (4) | VEHICLE/DRIVER pter 844 T hereby "YES" in the Out out of service st until the out of een restored to sa obtained. CONTACT WATER) | declare "Out of Service ickers service fe operating | CE NOTICE DRIVER Pursuant to TRC Chapter 644 I declare the driver Out of Service. No permit or require operate any motor A P Zerre COPY RECEIVED REPORT PREPARED | named on this to motor carrier shadriver to drive driver to drive vehicle until | eport Obtai | Paired at Scene / ned Oper. Auth. wed/Escorted to it Service ther khown river OOS |
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| D'ACHICLE Pursuant to authority contained in TRC Chaff Service" the vehicle/s with defects followed by column of this report. No person shall remove the applied to these vehicles or operate such vehicles defects have been repaired and the vehicles have be condition, or proper operating authority has been SEE CONTINUATION SHEET TROOPER COMMENTS: FLAMMABLE LIQUID NOS UN 1268 FG II (COKER GAS VIN #1 (0) (4) INSPECTED BY: ID/REGION/MILLER, STEPHEN A 0447 | VEHICLE/DRIVER pter 644 T hereby "YES" in the out out of service st until the out of een restored to sa obtained. CONTACT WATER) DISTRICT/AREA [1] 6 3 A 03 [1] | declare "Out of Service ickers service fe operating of Service fe operating of | CCE NOTICE DRIVER Pursuant to TRC Chapter 644 I declare the driver out of Service. No operate any motor A P James COPY RECEIVED REPORT PREPARED I REFERRAL ID | named on this to motor carrier sh driver to drive vehicle until | eport Obtai | Paired at Scene / ned Oper. Auth. wed/Excorted to it Service ther kinown iver OOS |

CES ENVIRONMENTAL SERVICES, INC.

32817

Judge Lorraine Lopez

Citation for Noah Berry

9/28/2007

320.00

CES Environmental S CP# 0151818 / TX07730ABV0D

320.00

Cardido requested
July trial set fa
9-28-2007 @ 8 am.
If he chose not to
go to the trial need to
pay \$ 520 (\$260+260)
to nettle.

\$260 \$260 \$520

SHOREACRES MUNICIPAL COURT

601 SHOREACRES BLVD SHOREACRES, TEXAS 77571 281-471-3340

Payment of fines may be made in person Monday - Thursday 7:30 a.m. to 5:30 p.m. Friday 7:30 a.m. to Noon.

If payments are made in full prior to your court date, your appearance is not necessary. However, it is recommended that you contact the court clerk 48 hours prior your court date and check that your payment was received.

PAYMENTS WILL ONLY BE ACCEPTED IF THE DEFENDANT (DRIVER) ENTERS A PLEA AND SIGNS THE BOTTOM PORTION OF THIS COPY

Acceptable method of payment includes, cash, money order, cashiers check, company check or personal checks.

FOR FINES AMOUNTS CONTACT THE COURT CLERK

If you are convicted of operating a motor vehicle without evidence of financial responsibility, your driver's license is subject to suspension by the Department of Public Safety.

REQUEST FOR TRIAL

If you choose to enter a plea of "NOT GUILTY" for the offense you are charged with and you would like to have trial on your case. YOU MUST appear on your scheduled court date listed on your citation. On your appearance date you will be given another date to reappear for trial.

CIT HOST HIS IN CITALOUS MININE CITALOUS HIS INC. Enclose this portion of the form with your payment

PAYMENTS WILL ONLY BE ACCEPTED IF THE DEFENDANT (DRIVER) ENTERS A PLEA AND SIGNS THE BOTTOM

Defendant's Name: Candido Rosales Case # 073 COD CYO2

I hereby enter a plea of [] GUILTY [NO CONTEST to the said offense(s) as charged, and waive my right to a Jury Trial, and agree to pay the penalty prescribed for my offense(s).

Signature:

Date: 5/11/07

Enclose this portion of the form with your payment

| TX073C0DCY02 | SHOREACRES POLICE DEPARTMENT | CD# - 01 F1 01 0 | | | | | |
|--|--|---|--|--|--|--|--|
| ARREST TKT 9 - 15 PASS. FOR HIRE | | CP#: 0151818 2 | | | | | |
| ☑ COM. VEH. ☐ 16 PASS. FOR HIRE | CONSTRUCTION ZONE | | | | | | |
| ☐ ACCIDENT ☐ 16 PASS. NOT FOR HIRE SPIN | PROG: INTERSTATE YES IN NO INTRASTATE OCCUPIED | SCALE ALCH DS | | | | | |
| | | SH-0146 IN HARRIS CO. (482- M.P.#; 497 | | | | | |
| LESSEE/MC: C E S ENVIROMENTAL SERVICES | | USDOT#: 0869392 | | | | | |
| ADD/CITY/ST/ZIP: 4904 GRIGGS RD (3901 TRAILMOB | ILE) HOUSTON TX 77013 | ICC/MC#: 400234 | | | | | |
| OWNER: C E S ENVIROMENTAL SERVICES | <u> </u> | TXDOT#: 005516524C | | | | | |
| ADD/CITY/ST/ZIP: 4904 GRIGGS RD (3901 TRAILMOB | LE) BOUSTON TX 77013 | PHONE#: 7136761460 | | | | | |
| OPERATOR: CANDIDO ALEXANDER ROSALES | RACE/SEX: EDM DOB: | (b) (4) MED CARD: NONE | | | | | |
| ADD/CITY/ST/ZIP: (b) (4) | DL #: (b) | ST: TX DL CLASS: | | | | | |
| VEH SEARCH: YES 🗹 NO REASON FOR STOP | : WARN CITATION CINSPECTION | CONTRABAND LOCATED: YES NO | | | | | |
| TYPE OF SEARCH: CONSENT PC INC. TO ARRE | ST INVENTORY TYPE OF CONTRABAND: | DRUGS WEAPONS CURRENCY OTHER | | | | | |
| \overline{v} | NIT TYPE MAKE CO# PLATE | | | | | | |
| 28 | 1 TT PTRB 290 (b) (4) 2 ST FRUE 218 | ME 49 LD 40 MART PROPERTY LARGE DAY FEMBRE OF EXPRESS OF | | | | | |
| X | 2 3 102 220 | | | | | | |
| SIGNATURE: | | 01 2-10 11 1-10 11 11 11 11 11 11 11 11 11 11 11 11 1 | | | | | |
| I HEREBY PROMISE TO APPEAR AT THE TIME AND | | | | | | | |
| PLACE DESIGNATED IN THIS NOTICE. (THIS IS NOT A PLEA OF GUILTY) | 00 00 | | | | | | |
| | · | The transfer | | | | | |
| V 001 1 1001100 01 | | P WEIGHT: | | | | | |
| YOU ARE HEREBY NOTIFIED TO APPEAR | LOAD I | DISP: | | | | | |
| JUDGE: COURT: Municipal | PCT./PLACE; 0/1 PERMIT | · #: | | | | | |
| PHONE: (281) 471-3340 ON/BEFORE 14-Jun-2 | 10 41 | | | | | | |
| ADDRESS: 601 SHOREACRES BLVD SHOREACRES TX 77571 | RG WT | | | | | | |
| SEAL #'S REMOVED: DEPT. SEAL #; INSTALLED | D CVSA DECAL-TT CVSA DECAL-ST | CVSA DECAL-ST | | | | | |
| 0347960 | GULF BAYPORT CHEMICALS | GALVESTON COUNTY | | | | | |
| SHIPPING #: CO | NSIGNOR: | ONSIGNEE: | | | | | |
| COMMODITY: FATS AND OILS TANK BOTTOMS OR | IGIN: PASADENA TX D | ESTINATION: ALTA LOMA TX | | | | | |
| | ACARDS REQ? | ALLEGED SPEED | | | | | |
| NA NA | D AX 1 AY 2 AY 3 AY 4 AY 5 A | SPEED LIMIT | | | | | |
| | SPEC. TANK | RADAR CAL. | | | | | |
| DTCWTGIVTOY OTDE AILU-1-1 OOC LOOK DOOR | | | | | | | |
| TICKET VIOL. CITE # Unit OOS OOS POST No. Y/N DISP ACC DI | VIOLATIONS DISCO RIVER: PLEASE COMPLY WITH DIRECTIONS ON BACK | · | | | | | |
| Yes 391.41(a) D NO MEDICI | AL CERTIFICATE ON PERSON (CARD) - DRI | VER CLAIMS DID NOT GET MEDICAL CARD | | | | | |
| Yes 396.17(c) 2 EXPIRED (| MV INSPECTION CERTIFICATE / ANNUAL D | OT - NO CURRENT STICKER OR PAPERWORK | | | | | |
| 393.95(a) 1 FIRE EXTIN | | | | | | | |
| | | | | | | | |
| 393.11 2 DEFECTIVE ID LAMP (FRONT/REAR) - MISSING | | | | | | | |
| | | | | | | | |
| VEU | CLE/DRIVER OUT OF SERVICE NOTICE | | | | | | |
| VEHICLE Pursuant to authority contained in TRC Chapter 644 I hereby declare "Out DRIVER Pursuant to authority contained in 1008 DISPOSITIONS | | | | | | | |
| column of this report. No person shall remove the out | of service stickers declare the driver | hereby notify and A. Repaired at Scene / Obtained Oper. Auth. | | | | | |
| applied to these vehicles or operate such vehicles unti defects have been repaired and the Vehicles have been r | estored to safe operating permit or require of | | | | | | |
| condition, or proper operating authority has been obtained CONTINUATION SHEET TROOPER COMMENTS: | ned. operate any motor | U. Unknown | | | | | |
| 3500 SH 146 S/B FROM CHOATE RD. DRIVER# CELL. DRIVER SAID | | | | | | | |
| OFFICE WAS MAILED RESULTS AND ALL THE PAPERWORK FRO | X | | | | | | |
| | COPY RECEIVED | Log Book Exemption | | | | | |
| | RICT/AREA TIME COMPLETED REPORT PREPARED F | | | | | | |
| MANOLESCU, DODEUS P. 2Q-000906 | = (| DV. | | | | | |
| CHARGES FILED BY: MANOLESCU, DODEUS P. 2Q-000 | BRAKES INSPECTED | DI. | | | | | |

ANY ENTRIES IN THE VIOLATIONS' SECTION OF DRIVER'S COPY, WHERE THERE IS "YES" IN THE TICKET BOX, INDICATES CHARGES FILED AGAINST THE DRIVER. THIS WILL REQUIRE CONTACTING THE JUDGE FOR APPROPRIATE DISPOSITION.

JUDGE INFORMATION IS IN HEAVY BORDERED BOX ON DRIVER'S COPY.

PAYMENTS FOR FINES SHOULD BE SENT TO THE COURT LISTED ON THE DRIVER'S COPY. DO NOT SEND PAYMENTS TO TX DPS/MCB.

CERTIFICATION OF REPAIRMAN

I CERTIFY THAT THE REQUIRED REPAIRS SHOWN IN THE "OUT OF SERVICE" COLUMN ON THE OTHER SIDE OF THIS CERTIFICATE HAVE BEEN SATISFACTORILY COMPLETED.

NAME OF SHOP (GARAGE): SIGNATURE OF REPAIRMAN: REPAIR WORK COMPLETED TIME

MOTOR CARRIER CERTIFICATION OF ACTION TAKEN

I CERTIFY THAT ALL VIOLATIONS NOTED UPON THIS REPORT HAVE BEEN CORRECTED AND ACTION HAS BEEN TAKEN TO ASSURE COMPLIANCE WITH THE MOTOR CARRIER SAFETY REGULATIONS INSOFAR AS THEY ARE APPLICABLE TO MOTOR CARRIERS AND DRIVERS.

SIGNATURE OF CARRIER OFFICIAL:

TITLE:

DATE:

HSE Manager

5-2-07

ATTENTION DRIVER:

This report must be furnished to the motor carrier whose name appears on this report.

ATTENTION DRIVER:

TRC Chapter 644, Revised Statutes, requires the Motor Carrier to execute the above certification

and return this report to: MOTOR CARRIER BUREAU

TEXAS DEPARTMENT OF PUBLIC SAFETY

PO BOX 4087

AUSTIN TX 78773-0521

IMPORTANT MESSAGES

Any enforcement actions taken against you and any subsequent court actions are intended to secure compliance with the traffic laws and all other users of the highways. Failure to comply with your written promise to appear in court as made on this citation will constitute a separate offense with which you may be charged and result in warrants being issued for your arrest. Failure to appear in court or failure to satisfy a judgement ordering payment of a fine and cost in the manner ordered by the court may result in the denial of renewal of your driver's license.

"A second or subsequent conviction of failure to maintain financial responsibility will result in the suspension of your driver license and motor vehicle registration unless you file and maintain proof of financial responsibility with the Department of Public Safety for two (2) years from the date of conviction. The Department may waive the requirements to file proof of financial responsibility if you file satisfactory evidence with the Department showing that at the time this citation was issued the vehicle was covered by a liability insurance policy or that you were otherwise exempt from the requirements to provide evidence of financial responsibility.

You may be able to require that this charge be dismissed by successfully completing a driving safety course or a motorcycle operator training course. You will lose that right if, on or before your appearance date, you do not provide the court with notice of your request to take the course. This article does not apply to an offense committed by a person who holds a commercial driver's license.

"A conviction of an offense under a traffic law of this state or a political subdivision of this state may result in the assessment on your driver's license of a surcharge under the Driver Responsibility Program."

A request for an out-of-service review, regarding operating authority, must be made in writing and forwarded to the manager of the Motor Carrier Bureau. If requested, a review will be scheduled and conducted by the manager of the Motor Carrier Bureau or the director's designee within 10 days of the issuance of the out-of-service order. A request for review should be addressed to the Texas Department of Public Safety, Motor Carrier Bureau, P.O. Box 4087, Austin, TX 78773-0521 or may be sent by facsimile transmission to (512) 424-5712 or via electronic mail at MotorCarrierBureau@txdps.state.tx.us. The Department may conduct the review by telephone conference call.

To obtain a TxDOT Motor Carrier Insurance Certificate or Single State Registration - contact the Texas Department of Transportation at 1-800-299-1700 or visit their website at www.dof.state.tx.us.

To obtain a USDOT Number contact the Federal Motor Carrier Safety Administration at 1-800-832-5660 or visit their website at www.fmcsa.dot.gov/factsfigs/formspubs.htm.

To obtain IFTA information contact the State of Texas Comptrollers Office at 1-800-252-1383 or visit their website at www.window.state.tx.us/taxinfo/fuels/ifta.html.

| TX073C0DCY02 | SHOREACRES POLICE DEPARTMENT | CD# - O1 F1 O1 O |
|---|---|--|
| ARREST TKT 9 - 15 PASS, FOR HIRE | | CP#: 0151818 2 |
| COM. VEH. 16 PASS. FOR HIRE | CONSTRUCTION | ZONE ☐FIXED ☑ROADSIDE |
| ACCIDENT 16 PASS, NOT FOR HIRE | | |
| CDL SCHEDULE CHARTER | | HOUSE SW TE |
| DATE: 04/30/2007 TIME: | 12:36PM COUNTY: HARRIS HWY: (| 2) SH-0146 IN HARRIS CO. (482- M.P.#: 497 |
| LESSEE/MC: C E S ENVIROMENTAL SERVICES | | USDOT#: 0869392 |
| ADD/CITY/ST/ZIP: 4904 GRIGGS RD (3901 T | RAILMOBILE) HOUSTON TX 77013 | ICC/MC#: 400234 |
| OWNER: C E S ENVIROMENTAL SERVICES | | TXDOT#: 005516524C |
| ADD/CITY/ST/ZIP: 4904 GRIGGS RD (3901 TF | RAILMOBILE) HOUSTON TX 77013 | PHONE#: 7136761460 |
| OPERATOR: CANDIDO ALEXANDER ROSALES | RACE/SEX: HM DOE | B: (b) (4) MED CARD: NONE |
| ADD/CITY/ST/ZIP: (b) (4) | DL #: | (b) (4) ST: TX DL CLASS: |
| VEH SEARCH: YES VNO REASON F | OR STOP: TWARN CITATION TINSPECTI | ON CONTRABAND LOCATED: TYES TNO |
| TYPE OF SEARCH: CONSENT PC INC. | TO ARREST INVENTORY TYPE OF CONTRABAND: | |
| THE OF SEARCH: CONSENT OF LINE. | UNIT TYPE MAKE CO# PLA | |
| | 1 TT PTRB 290 (b) (4 | |
| | 2 ST FRUE 218 | ME |
| X | | |
| O'GNATURE: | | |
| ☐ I HEREBY PROMISE TO APPEAR AT THE TIME A | AND. | |
| PLACE DESIGNATED IN THIS NOTICE. (THIS I | is | |
| NOT A PLEA OF GUILTY) | x 00 00 | |
| COPY RECEIVED BY | GROSS WEIGHT: G | ROUP WEIGHT: |
| YOU ARE HEREBY NOTIFIED TO APPEAR | LOF | AD DISP: |
| JUDGE: COURT: Municip | PCT./PLACE: 0/1 | RMIT #: |
| PHONE: (281) 471-3340 ON/BEFORE 1 | 4-Jun-2007 AT 7:00PM RG | |
| ADDRESS: 601 SHOREACRES BLVD SHOREACRES TX | <u> </u> | WT #2 GVWR #2 |
| SEAL #'S REMOVED: DEPT. SEAL #; IN | STALLED CVSA DECAL-TT CVSA DECAL-S | T CVSA DECAL-ST |
| | | |
| 0347960 | GULF BAYPORT CHEMICALS | GALVESTON COUNTY |
| SHIPPING #: | CONSIGNOR: | CONSIGNEE: |
| COMMODITY: FATS AND OILS TANK BOTTOM | IS ORIGIN: PASADENA TX | DESTINATION: ALTA LOMA TX |
| \ | HW? PLACARDS REQ? | ALLEGED SPEED |
| NA | | SPEED LIMIT |
| | SPEC. TANK AX 1 AX 2 AX 3 AX 4 AX | 5 AX 6 AX 7 AX 8 RADAR CAL. |
| | | |
| TICKET VIOL, CITE # Unit OOS OOS POST No. Y/N DISP ACC | VIOLATIONS DE | |
| | DRIVER: PLEASE COMPLY WITH DIRECTIONS ON MEDICAL CERTIFICATE ON PERSON (CARD) - I | |
| 1es D | | |
| Yes 396.17(c) 2 EXE | PIRED CMV INSPECTION CERTIFICATE / ANNUAL | L DOT - NO CURRENT STICKER OR PAPERWORK |
| 393.95(a) 1 FIR | e extinguisher Violation - Discharged | A. PANTONIA |
| 393.11 2 DEF | ECTIVE ID LAMP (FRONT/REAR) - MISSING | |
| | , | |
| | | |
| | | |
| | VEHICLE/DRIVER OUT OF SERVICE NOTICE | |
| — of Service, the Addicte's with defects followed | | i i nereby notity and |
| column of this report. No person shall remove applied to these vehicles or operate such vehic | les until the out of service Out of Service. | ver named on this report Obtained Oper. Auth. No motor carrier shall B. Towed/Escorted to |
| defects have been repaired and the vehicles hav condition, or proper operating authority has be | en obtained. operate any mot | re driver to drive or Repair Service or vehicle until D. Other |
| SEE CONTINUATION SHEET TROOPER COMMENTS | | U. Unknown N. Driver OOS |
| 3500 SH 146 S/B FROM CHOATE RD. DRIVER# OFFICE WAS MAILED RESULTS AND ALL THE PAPERS | | |
| | X | ✓ Log Book Exemption |
| <u> </u> | COPY RECEIV | |
| į į | ON/DISTRICT/AREA FIME COMPLETED REPORT PREPARE | ED BY: MANOLESCU, DODEUS P. |
| <u></u> | 000906 2 9 Q 1:20PM REFERRAL ID 20-000906 290 BRAKES INSPECT | TED BY: |
| CHARGES FILED BY: MANOLESCU, DODEUS P. | ΣÃ-ΛΩΩΑΩΩ ΣΑĞ BΩΛΥΓΟ ΤΩΣΑΨΟΙ | |

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CERTIFICATION OF REPAIRMAN

I CERTIFY THAT THE REQUIRED REPAIRS SHOWN IN THE "OUT OF SERVICE" COLUMN ON THE OTHER SIDE OF THIS CERTIFICATE HAVE BEEN SATISFACTORILY COMPLETED.

SIGNATURE OF REPAIRMAN: NAME OF SHOP (GARAGE): REPAIR WORK COMPLETED TIME

MOTOR CARRIER CERTIFICATION OF ACTION TAKEN
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TITLE: SIGNATURE OF CARRIER OFFICIAL:

HSE Manage

DATE: 5-2-07

ATTENTION DRIVER:

This report must be furnished to the motor carrier whose name appears on this report.

ATTENTION DRIVER:

TRC Chapter 644, Revised Statutes, requires the Motor Carrier to execute the above certification and return this report to:

MOTOR CARRIER BUREAU

TEXAS DEPARTMENT OF PUBLIC SAFETY PO BOX 4087

AUSTIN TX 78773-0521

IMPORTANT MESSAGES

Any enforcement actions taken against you and any subsequent court actions are intended to secure compliance with the traffic laws and all other users of the highways. Failure to comply with your written promise to appear in court as made on this citation will constitute a separate offense with which you may be charged and result in warrants being issued for your arrest. Failure to appear in court or failure to satisfy a judgement ordering payment of a fine and cost in the manner ordered by the court may result in the denial of renewat of your driver's license.

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To obtein a TxDOT Motor Carrier Insurance Certificate or Single State Registration - contact the Texas Department of Transportation at 1-800-299-1700 or visit their website at www.dot.state.bx.us.

To obtain a USDOT Number contact the Federal Motor Carrier Safety Administration at 1-800-832-5660 or visit their website at www.fmcsa.dot.gov/factsfigs/formspubs.htm.

To obtain IFTA information contact the State of Texas Comptrollers Office at 1-800-252-1383 or visit their website at www.window.state.tx.us/taxinfo/fuels/ifta.html.



City of Shoreacres

6CI SHOREACRES BOULEVARD SHOREACRES, TEXAS 77571 PHONE (281) 471-2244 FAX (281) 471-8955

FAX COVER SHEET

| Date: | 5-11-07 | |
|---------------|-------------|----|
| To: | Prabhakar | |
| Fax No: | 713-676-167 | |
| From: | Bronda | |
| Fax No: | 281 471 85 | 35 |
| Number of pag | jes:2 | |
| | | |
| Additional In | nformation: | • |
| | | |
| | | |
| | | |
| | | |

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DO NOT SEND PAYMENTS TO TX DPS/MCB.

CERTIFICATION OF REPAIRMAN I CERTIFY THAT THE REQUIRED REPAIRS SHOWN IN THE "OUT OF SERVICE" COLUMN ON THE OTHER SIDE OF THIS CERTIFICATE HAVE BEEN SATISFACTORILY COMPLETED. SIGNATURE OF REPAIRMAN: NAME OF SHOP (GARAGE): REPAIR WORK COMPLETED DATE: JATE: JATE: JATE: REPAIR WORK COMPLETED DATE: JATE: ATTENTION DRIVER:

This report must be furnished to the motor carrier whose name appears on this report.

ATTENTION DRIVER:

TRC Chapter 644, Revised Statutes, requires the Motor Carrier to execute the above certification

and return this report to: MOTOR CARRIER BUREAU

TEXAS DEPARTMENT OF PUBLIC SAFETY

PO BOX 4087

AUSTIN TX 78773-0521

IMPORTANT MESSAGES

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| TX07730ABV0D | TXDPS COMMERCIAL VEHICLE ENFORCEMENT | LEVEL |
|---|---|--|
| ARREST TKT 9 - 15 PASS. FOR HIRE | | CP#: 0121818 2 |
| ☐ COM. VEH. ☐ 16 PASS. FOR HIRE ☐ ACCIDENT ☐ 16 PASS. NOT FOR HIRE | CONSTRUCTION ZOI | |
| ☐ CDL ☐ SCHEDULE ☐ CHARTER | SP PROG: ☑ INTERSTATE ☐ YES ☑ NO ☐ INTRASTATE ☐ OCCUPIED | SCALE ALCH DS HOUSE 3A307 SW TE |
| l — — — — — | | US-0077 IN REFUGIO CO. (60(M.P.#: 624 |
| LESSEE/MC: | | USDOT#: 0869392 |
| ADD/CITY/ST/ZIP: | | ICC/MC#: 400234 |
| OWNER: O E S ENVIROMENTAL SERVICES | | TXDOT#: 005516524C |
| ADD/CITY/ST/ZIP: 4904 GRIGGS RD (3901 TRA | ILMOBILE) HOUSTON TX 77013 | PHONE#: 7136761460 |
| OFERATOR: NOAH DEAN BERRY | RACE/SEX: BM DOB: | (b) (4) MED CARD: 5-6-08 |
| ADD/CITY/ST/ZIP: (b) (4) | DL #: | ST: TX DL CLASS: A |
| veh search: 🗌 yes 📝 no Reason fof | STOP: WARN CITATION TINSPECTION | CONTRABAND LOCATED: YES NO |
| TYPE OF SEARCH: CONSENT PC INC. TO | ARREST INVENTORY TYPE OF CONTRABAND: | ☐DRUGS ☐WEAPONS ☐CURRENCY ☐OTHER |
| | UNIT TYPE MAKE CO# PLAT | E ST |
| 00 78 | 1 TT PTRB 287 (5) (4) | TX ME II() R II AIREN III DINATERE ETERIT EN EN EN EN EN |
| x 97 Berry | 2 31 1700 37281 | |
| SIGNATURE: | ~ Jehu. | 15 .50 |
| ☐ I HEREBY PROMISE TO APPEAR AT THE TIME AN | RET AT | 05 (=de |
| PLACE DESIGNATED IN THIS NOTICE. (THIS IS | | 10 |
| NOT A PLEA OF GUILTY) | x 00 00 mg. | <i>v</i> |
| ☑ COPY RECEIVED BY | | DUP WEIGHT: |
| YOU ARE HEREBY NOTIFIED TO APPEAR | LOAD | DISP: |
| | | IT #: |
| PHONE: • (361) 526-4877 ON/MEFORE 28- | 1100 (1 | T #1 80,000 GVWR #1 |
| ADDRESS: 808 COMMERCE REFUGIO TX 18377 SEAL 4'S REMOVED: DEPT. SEAL 4: INS | | T #2 0 GVWR #2 65,000 |
| SEAL #'S REMOVED: DEPT, SEAD #7 INS | TALLED CVSA DECAL-TT CVSA DECAL-ST | CVSA DECAL-ST |
| 48535 | TRANSMONTAINGE PRODUCT | CES ENVIROMENTAL |
| SHIPPING #: | CONSIGNOR: | CONSIGNEE: |
| COMMODITY: FLAMMABLE LIQUIDS | ORIGIN: | DESTINATION: HOUSTON TX |
| | W? PLACARDS REQ? | ALLEGED SPEED |
| BOLK 3 | SPEC. TANK AX 1 AX 2 AX 3 AX 4 AX 5 | SPEED LIMIT AX 6 AX 7 AX 8 RADAR CAL. |
| | 407 L | CAL. |
| TICKET, VIOL. CITE # Unit OOS OOS (POST) | VIOLATIONS DISC | COVERED |
| No. Y/N DISP ACC | DRIVER: PLEASE COMPLY WITH DIRECTIONS ON BA | |
| les 1 les Aj | E-HOSE/TUBE DAMAGED AND/OR LEAKING ~ | |
| Yes 172.328D 2 FAII | URE TO PROPERLY MARK MANUAL REMOTE SHUTC | OFF DEVICE - |
| | | |
| | | |
| | | |
| } | | |
| | VEHICLE/DRIVER OUT OF SERVICE NOTICE | |
| YCHICLE Pursuant to authority contained in TRC C of Service" the vehicle/s with defects followed | hapter 644 I hereby declare "Out DRIVER Pursuant" by "YES" in the Out of Service TRC Chapter 644 | to authority contained in OOS DISPOSITIONS I hereby notify and A. Repaired at Scene / |
| column of this report. No person shall remove t applied to these vehicles or operate such vehicl | he out of service stickers declare the driv es until the out of service Out of Service. I | er named on this report Obtained Oper. Auth. No motor carrier shall B. Towed/Escorted to |
| defects have been repaired and the vehicles have condition, or proper operating authority has bee | | |
| SEE CONTINUATION SHEET TROOPER COMMENTS: FLAMMABLE LIQUID NOS UN 1268 PG II (COKER GA | S CONTACT WATER) | U. Unknown N. Driver 005 |
| | X97 Zery | |
| VIN #1 (6) | <u> </u> | Log Book Exemption |
| INSPECTED BY: ID/REGION | COPY RECEIVE I/DISTRICT/AREA TIME COMPLETED REPORT PREPARE | |
| | 76 3 A 03 10:02AM REFERRAL ID | |
| CHARGES FILED BY: MILLER, STEPHEN A 044 | 76 3AO3 BRAKES INSPECTE | ED BY: |



JÚSTICE COURTS OF REFUGIO COUNTY

LORRAINE LOPEZ
JUSTICE OF THE PEACE, PCT. #1
808 COMMERCE, ROOM 111
REFUGIO, TEXAS 78377
OFFICE (361)526-4877/FAX (361)526-4819

PLEASE READ THIS LETTER BEFORE CALLING!

This letter is furnished as a courtesy to you by the Justice Courts of Refugio County, Texas to assist you in making disposition of the charge or charges filed against you.

If you wish to enter a plea of guilty or nolo contendere, please indicate in the proper space provided. A plea of Nolo Contendere, means that you do not contest the state's charge(s) against you. The fine for a nolo contendere plea is the same as that for a plea of guilty. Either plea indicates that you agree to waive appearance before the court for trial.

You must refer to the schedule on the reverse side of this letter to determine the total amount of vour fine(s) and the costs assessed against vou. Make vour remittance by CASHIER'S CHECK, MONEY ORDER (NO COMPANY CHECKS, CASH or PERSONAL CHECKS ACCEPTED.) to the Justice Court encircled at the top of this letter. Return a copy of the citation and this letter with your remittance to assure proper credit.

If you wish to enter a plea of "NOT GUILTY" and desire a trial, you must so indicate in the proper space provided. If you enter a plea of "NOT GUILTY", you must make appearance before the Court. You must return this letter, and our copy of the citation not later than the APPEARANCE date shown on the citation. You shall be notified by return mail of the court date set for your hearing. You have the right to a trial by jury, if you so request. A PLEA MUST BE ENTERED WITH PAYMENT.

WARNING

FAILURE TO RESPOND TO THE CHARGE(S) BY THE APPEARANCE DATE SHOWN ON YOUR CITATION WILL RESULT IN AN ADDITIONAL CHARGE OF "FAILURE TO APPEAR" OF WHICH THE FINE IS \$200.00 AND ISSUANCE OF A WARRANT FOR YOUR ARREST. THE COURT MAY ALSO DENY RENEWAL OF YOUR DRIVER'S LICENSE.

SCHEDULE OF ACCEPTABLE FINES

| | Gross Weight and Axle Violations (Including 1547 permit violations): | |
|---|--|-----------------|
| | Over weight-Less than 5,000 lbs. | \$ 250.0 |
| | Over weight-5,000 lbs. To 10,000 lbs. | 470.0 |
| | Over weight-Over 10,000 lbs. | 750.0 |
| | Permit Violations | 300.0 |
| | No Motor Carrier Authority(ICC CAB CARD) | 160.0 |
| | No or Improper reflective Material | 160.0 |
| | No or Improper Commercial Motor Vehicle Signs or Markings | (160.0 |
| | Fire Extinguisher Violation | T60:0 |
| | No CDL Driver's License | 250.0 |
| | No/Expired Registration or MVI Certificate | 160.0 |
| | No Hazardous Materials Shipping Papers | 160.0 160.0 |
| | No Medical Card on Person Display/Fail to Display Hazardous Material Placards When Needed/Not Needed | 160.0 |
| | Oversize-All Width, Length, height Violations | 160.0 |
| | Improper Loading Loose Materials, and Inadequate Bed Violations | 160.0 |
| | No/Improper Load Securement | 160.0 |
| | No/Improper Load Securement - Intermodal Container | 160.0 |
| _ | All Vehicle Equipment Violations (Defective Brakes, Lights, Etc.) | (160.0) |
| 7 | Operating Out of Service Vehicle | 250.0 |
| | No Current Record of Duty Status | 160.0 |
| | False Log Book | 250.0 |
| | Over Hours Driving | 160.0 |
| | No Proof of Liability Insurance | 340.0 |
| | Disregard Traffic Control Sign | 160.0 |
| | No/Fail To Display TX DOT Insurance Certificate | 160.0 |
| | No Annual DOT Inspection | 160.0 |
| | Driving with Detectable Amount of Alcohol About Person | 250.0 |
| | Illegal Extension to Rear | 160.0 |
| | Fail to Display Current License Receipts | 160.0 |
| | Driver in Possession of Radar Detector | 200.0 |
| | Brakes Out of Adjustment | 160.0 |
| | NO SAFETY BELT | 160.0 |
| | ************************************* | **** |
| | FOR ANY VIOLATIONS NOT LISTED, CONTACT COURT. | |
| | AN ADDITIONAL CHARGE OF \$2500 WILL BE CHARGED FOR PAYMENT ARRANGEN | MENTS. |
| | *************************************** | ****** |
| | | |
| | REPLY FORM Mail to the Justice Court CIRCLED at the top of the latter BY the APPEARANCE DATE on the cit | |
| | Mail to the Justice Court CIRCLED at the top of the leder BY the APPEARANCE DATE on the cit | ation. |
| | CHECK ONE OF THE BELOW: | |
| | Company of the compan | |
| | 1. I hereby enter a plea of GUILTY and waive appearance at trial. A CASHIER'S CHEC | <u>T, MONEY</u> |
| | ORDER in the amount of fine (s) is enclosed. | |
| | | |
| | 2. I hereby enter a plea of NOLO CONTENDERE an waive appearance for trial. A CASH | <u>IER'S</u> |
| | CHECK, MONEY ORDER in the amount of fine(s) is enclosed. | |
| | The state of the s | TO CT Y |
| | I hereby enter a plea of <u>NOT GUILTY</u> and request of (jury or non-jury trial). C ONE I (Will or Will Not) be represented by counsel. | IKULE |
| | ONE I (will or will not) be represented by counsel. | |
| | DATE:SIGNATURE: | |
| | DATE: SIGNATURE: | |
| | YET A TRATTA TOTAL (C.A | |
| | WARNING: "A conviction of an offense under a traffic law of this state or a politic | |
| | subdivision of this state may result in the assessment on your driver's license of a si | ırcharge |
| | under the Driver Responsibility Program. | - |
| | | |

CK, S CHECKS S CASH RECEIPT DATE NAME DOCKET NO. TICKET NO.

29651

THE MUNICIPAL COURT OF SHOREACRES

601 SHOREACRES BOULEVARD SHOREACRES, TEXAS 77571 281-471-3340

RETAIN THIS RECEIPT FOR YOUR RECORDS

R Ddvide



City of Shoreacres

City of Shoreacres

MUNICIPAL COURT

601 SHOREACRES BOULEVARD SHOREACRES, TEXAS 77571 281-471-3340

A COMMUNITY OF BEAUTIFUL HOMES ON GALVESTON BAY HOME OF THE HOUSTON YACHT CLUB

| MAYOR Nancy R. Edmonson | COURT CLERK Brenda Kent |
|---|----------------------------|
| Date: 6.14.07 Candido Rosales | |
| Condido Bosales | |
| | |
| | · · · · |
| Re: Cause Number: 0730 07 Cya Offense: No pled Cart or Defendant: | pason -NO CMU Inspece |
| Time: SAM Date: | _ |
| () Trial to Court and I expressly waive Jury | |
| () Arraignment [Jury] | |
| () Pre-trial | |
| Municipal Court Clerk/Deputy Court Clerk | Defendant |

ANY ENTRIES IN THE VIOLATIONS' SECTION OF DRIVER'S COPY, WHERE THERE IS "YES" IN THE TICKET BOX, INDICATES CHARGES FILED AGAINST THE DRIVER. THIS WILL REQUIRE CONTACTING THE JUDGE FOR APPROPRIATE DISPOSITION.

JUDGE INFORMATION IS IN HEAVY BORDERED BOX ON DRIVER'S COPY.

PAYMENTS FOR FINES SHOULD BE SENT TO THE COURT LISTED ON THE DRIVER'S COPY.

DO NOT SEND PAYMENTS TO TX DPS/MCB.

| I CERTIFY THAT THE REQUIRED RE OF THIS CERTIFICATE HAVE BEEN | PAIRS SHO | | OF SE | | N ON THE OTHER SIDE |
|--|-------------------------------------|------------------------------|-------|-----------------------|---------------------|
| SIGNATURE OF REPAIRMAN: | NAME OF SI | NAME OF SHOP (GARAGE): | | REPAIR WORK COMPLETED | |
| | | | | DATE: | TIME: |
| I CERTIFY THAT ALL VIOLATIONS N BEEN TAKEN TO ASSURE COMPLI THEY ARE APPLICABLE TO MOTOR | NOTED UPOI ANCE WITH CARRIERS | V THIS REPORT THE MOTOR C | HAVE | SAFETY REGU | TED AND ACTION HAS |
| SIGNATURE OF CARRIER OFFICIAL: | TITLE: | | | DATE: | |

ATTENTION DRIVER:

This report must be furnished to the motor carrier whose name appears on this report.

ATTENTION DRIVER:

TRC Chapter 644, Revised Statutes, requires the Motor Carrier to execute the above certification

and return this report to: MOTOR CARRIER BUREAU

TEXAS DEPARTMENT OF PUBLIC SAFETY PO BOX 4087

AUSTIN TX 78773-0521

IMPORTANT MESSAGES

Any enforcement actions taken against you and any subsequent court actions are intended to secure compliance with the traffic laws and all other users of the highways. Failure to comply with your written promise to appear in court as made on this citation will constitute a separate offense with which you may be charged and result in warrants being issued for your arrest. Failure to appear in court or failure to satisfy a judgement ordering payment of a fine and cost in the manner ordered by the court may result in the denial of renewal of your driver's license.

"A second or subsequent conviction of failure to maintain financial responsibility will result in the suspension of your driver license and motor vehicle registration unless you file and maintain proof of financial responsibility with the Department of Public Safety for two (2) years from the date of conviction. The Department may waive the requirements to file proof of financial responsibility if you file satisfactory evidence with the Department showing that at the time this citation was issued the vehicle was covered by a liability insurance policy or that you were otherwise exempt from the requirements to provide evidence of financial responsibility.

You may be able to require that this charge be dismissed by successfully completing a driving safety course or a motorcycle operator training course. You will lose that right if, on or before your appearance date, you do not provide the court with notice of your request to take the course. This article does not apply to an offense committed by a person who holds a commercial driver's license.

"A conviction of an offense under a traffic law of this state or a political subdivision of this state may result in the assessment on your driver's license of a surcharge under the Driver Responsibility Program."

A request for an out-of-service review, regarding operating authority, must be made in writing and forwarded to the manager of the Motor Carrier Bureau. If requested, a review will be scheduled and conducted by the manager of the Motor Carrier Bureau or the director's designee within 10 days of the issuance of the out-of-service order. A request for review should be addressed to the Texas Department of Public Safety, Motor Carrier Bureau, P.O. Box 4087, Austin, TX 78773-0521 or may be sent by facsimile transmission to (512) 424-5712 or via elactronic mail at Motor Carrier Bureau@txdps.state.tx.us. The Department may conduct the review by telephone conference call.

To obtain a TxDOT Motor Carrier Insurance Certificate or Single State Registration - contact the Texas Department of Transportation at 1-800-299-1700 or visit their website at www.dot.state.tx.us.

To obtain a USDOT Number contact the Federal Motor Carrier Safety Administration at 1-800-832-5660 or visit their website at www.fmcsa.dot.gov/factsfigs/formspubs.htm.

To obtain IFTA information contact the State of Texas Comptrollers Office at 1-800-252-1383 or visit their website at www.window.state.tx.us/taxinfo/fuels/lifta.html.



City of Shoreacres

MUNICIPAL COURT

601 SHOREACRES BOULEVARD SHOREACRES, TEXAS 77571 281-471-3340

| | • | |
|---|--|--|
| A COI | MMUNITY OF BEAUTIFUL HOMES O | N GALVESTON BAY |
| | HOME OF THE HOUSTON YACH | T CLUB |
| | | |
| | | |
| MAYOR | | COURT CLERK |
| Nancy R. Edmonson | | Brenda Kent |
| | | |
| | | |
| 1 112-3 | | |
| Date: | | |
| Date: 6.14.07 Candido Rosales | | |
| Condido Rasales | •• | |
| | | |
| | | |
| | : | |
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| | | |
| | | |
| Re: Cause Number: 073C | DD CUST | |
| Re: Cause Number: | 200 | |
| Re: Cause Number: 073C . Offense: No pled C. | ant ongason - N | ormo Inspe |
| Defendant: | | |
| | | |
| | | |
| The state of the transfer of the | O - C-H | • |
| The above cited has been set/reset for t | | |
| Q Am | Date: <u>9-28</u> | 07 |
| Time: | Date: | |
| | | |
| | | v |
| () Trial to Court and I expressly waive | Jury | |
| | | |
| () Arraignment | | |
| | | |
| (Jury) | | |
| X X X | | |
| () Pre-trial | | |
| () Tie-mai | and the same of th | and the same of th |
| (V) | | |
| 1) Chi | | |
| | Same and the same | |
| Municipal Court Clerk/Deputy Court C | lerk Defendant | |
| City of Shoreacres | | |
| | - 1 <u>25</u> 274 | |

| | | سريعير | 127651 | 1/28 | Landedo | 1103132406 | CYOZ |
|-----------|----------|---------|----------------|------|---------|------------|---------------|
| CK. NO | s CHECKS | \$ CASH | RECEIPT NO. | DATE | NAME | DOCKET NO. | TICKET NO. |

29651

THE MUNICIPAL COURT OF SHOREACRES
601 SHOREACRES BOULEVARD
SHOREACRES, TEXAS 77571
281-471-3340

| TX073C0DCY02 | SHOREACRES POLICE DEPARTMENT | CD# - O1 E1 O1 O | | | |
|--|--|---|--|--|--|
| ☑ ARREST TKT ☐ 9 - 15 PASS. FOR H | | CP#: 0151818 2 | | | |
| COM. VEH. 16 PASS. FOR HIRE | CONSTRUCTION ZONE | E PIXED PROADSIDE | | | |
| ACCIDENT 16 PASS. NOT FOR H | 120 (V) NO | SCALE ALCH DS | | | |
| | | | | | |
| | | 98-0146 IN HARRIS CO. (482- M.P.#: 497 | | | |
| LESSEE/MC: C E S ENVIROMENTAL SERVICES ADD/CITY/ST/ZIP: 4904 GRIGGS RD (3901 | | USDOT#: 0869392 | | | |
| | TRAILMOHILE) HOCOTON IX //UL3 | ICC/MC#: 400234 | | | |
| OWNER: C E S ENVIROMENTAL SERVICES | | TXDOT#: 005516524C | | | |
| | TRAILMOBILE) HOUSTON TX 77013 | PHONE#: 7135761460 | | | |
| | RACE/SEX: HM DOB: | MED CARD: NONE | | | |
| ADD/CITY/ST/ZIP: (b) (4) | | | | | |
| | FOR STOP: WARN CITATION DINSPECTION | CONTRABAND LOCATED: TYES NO | | | |
| TYPE OF SEARCH: CONSENT PC INC | TO ARREST INVENTORY TYPE OF CONTRABAND: | | | | |
| | UNIT TYPE MAKE CO# PLATE 1 TT PTRB 290 (4) | 51 7X | | | |
| 1 | 2 ST FRUE 218 | ME | | | |
| IX (III) | | | | | |
| SIGNATURE: | | | | | |
| ☐ I HEREBY PROMISE TO APPEAR AT THE TIM | E AND | | | | |
| PLACE DESIGNATED IN THIS NOTICE. (THE NOT A PLEA OF GUILTY) | S IS X 00 00 | | | | |
| | 1. | O METON | | | |
| COPY RECEIVED BY | | P WEIGHT: | | | |
| YOU ARE HEREBY NOTIFIED TO APPEAR | LOAD | DISP: | | | |
| JUDGE: COURT: Munic | PERMIT | r #: | | | |
| PHONE: (281) 471-3340 ON/BEFORE | 14-Jun-2007 AT 7:00PM RG WT | | | | |
| ADDRESS: 501 SHOREACRES BLVD SHOREACRES | | | | | |
| SEAL #'S REMOVED: DEPT. SEAL #; | INSTALLED CVSA DECAL-TT CVSA DECAL-ST | CVSA DECAL-ST | | | |
| | | | | | |
| SHIPPING #: 0347960 | CONSIGNOR: GULF BAYPORT CHEMICALS | CONSIGNEE: GALVESTON COUNTY | | | |
| COMMODITY: FATS AND OILS TANK BOTT | COME ORIGIN: PASADENA TX | ESTINATION: ALTA LOMA TX | | | |
| HM CATEGORY CODE RO | | ALLEGED SPEED | | | |
| NA | | SPEED LIMIT | | | |
| | SPEC. TANK AX 1 AX 2 AX 3 AX 4 AX 5 A | AX 6 AX 7 AX 8 RADAR CAL. | | | |
| | | | | | |
| TICKET VIOL. CITE # Unit OOS OOS POST No. Y/N DISP ACC | VIOLATIONS DISCO | | | | |
| | DRIVER: PLEASE COMPLY WITH DIRECTIONS ON BACK TO MEDICAL CERTIFICATE ON PERSON (CARD) - DRI | | | | |
| | EXPIRED CMV INSPECTION CERTIFICATE / ANNUAL D | ON TO COMPANY CHICAPP OF PARELLODY | | | |
| Yes 396.17(c) 2 | EAPTRED CHV INSPECTION CERTIFICATE / ANNOAL D | OT - NO CORRENT STICKER OR PAPERWORK | | | |
| 393.95 (a) 1 | TRE EXTINGUISHER VIOLATION - DISCHARGED | _ | | | |
| 393.11 2 | DEFECTIVE ID LAMP (FRONT/REAR) - MISSING | | | | |
| | | | | | |
| | | | | | |
| | VEHICLE/DRIVER OUT OF SERVICE NOTICE | | | | |
| D VEHICLE Pursuant to authority contained in T of Service" the vehicle/s with defects follo | RC Chapter 644 T hereby declare "Out | authority contained in OOS DISPOSITIONS | | | |
| column of this report. No person shall remo applied to these vehicles or operate such ve | ve the out of service stickers declare the driver | hereby notify and A. Repaired at Scene / named on this report Obtained Oper. Auth. motor carrier shall B. Towed/Escorted to | | | |
| defects have been repaired and the vehicles condition, or proper operating authority has | have been restored to safe operating permit or require | driver to drive or Repair Service | | | |
| SEE CONTINUATION SHEET TROOPER COMME | Vinc. | U. Unknown N. Driver 005 | | | |
| 3500 SE 146 S/B FROM CHOATE RD. DRIVER# (0) (4) CELL. DRIVER SAID OFFICE WAS MAILED RESULTS AND ALL THE PAPERWORK FROM HIS PHYSICAL. | | | | | |
| • | X | ✓ Log Book Exemption | | | |
| | COPY RECEIVED | | | | |
| | GION/DISTRICT/AREA FIME COMPLETED REPORT PREPARED | BY: MANOLESCU, DODEUS P. | | | |
| MANOLESCU, DODEUS P. 20 CHARGES FILED BY: MANOLESCU, DODEUS P. | | BY: | | | |
| | COOSOO CS DIGHTED INCENCIND | ! | | | |

2nd drawer down Labolil " safrify"

HP

Jacy Sulfer-Incident 12-18-68
PACES

EPAHO042001351

rain Crouse, Tx Mathd 1-800-859-5995 Ext 7291 TCEQ- Airclas 19-09.
Bubby Aguilas 19-09



Made in USA

(b) (4)

LAMER 91

On 12-18-08 Ricky CAME into my office after the ambulance took Joey to the hospital. Ite a shed me what had happened and it Joey had died. I gave him a brief statement of what had happened and that I did not know it Joey was clear. I could tall by Ricky's ale meanor that he was upset angry with what had happened with Joey and, I could tell he thought I was with holding information or giving him the "Company Line". I assured him that I truley did not know the status of Joey. The last thing I know at that time was that the fire department said Joey had a pulse when he left in the ambulance.

Ricky then began to say, to the effect "If Joey is clear he was quitting. That he was going to save his life and, every body else's life."
"That I should ask Melton Melton knows his people. That if something were to happen to Ricky

that his people would take CES out."

my shoolders, and told him't don't know.

Ricky then walked out of my office with an apperant attitude. Deter that evening I relayed what transpired in my office.

... Cont.

Frieldy morning I earlied Ricky on his
work phone asking him where he was and
asked him if he was comming to Port
Arther today. He toleme "He saintleston
He told me in a very adm and unsure
tone that he was in Houston and probably
not comming out to Port Arther that day"
I told him "OK-Thanks and if he knew
if Melton was comming or anybody else, and
he said he didn't know.

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one and the state of the state

WILBNUR 12-23-08 Al Greenie)
Super hawyer

Melissa Moore

Mark - P. West

Through Quan X

b) (4)

This lawyer has called me serval time and I have refused to talk to her. Gregory Lawrence wants me to talk to a triend that works with OSHA an he wants me to tell them that CE.S is discriminating blacks. Mark told me if I could get the parents of Joey to talk to their lawyer I was promised tem thousand dollars. So I called Rick tupes to get the number of Joey's parents and gave it to Mark, 30 to 45 minuuts later Kick Turros called me back saying he was going to tell the Office of C.E.S. what was going on to save his job, so when I heard that I complety backed out. I've seem Perry West in the white Chery Theo leave from C. E. S. To go meet Quan and Mark and go back to work Quan, Mark. P- West. D spoke with Pareyl Thousan, about him falling out at work. Darry | told them it had nothing to do with diabetes. MARK also told Quan that MAH threatened his life, so Mark tried to get a concealed weapons license and was denied because of crimanal history

Quam was mad at Gregory Lawrance and Mark Smith because they was telling me to talk to O.S.H.A. and telling me what to say which was how I knew that C-E-5 had payed David under the table to say he slipped and fell and it was nothing chemically involved.

Achief Braman products

Box asked Joey to get a sample out of a tanker parked on the line. Suzi followed to help Joey. Joey was on top of the tanker an Suzi was on the ladder. I. Rickey was working in my drum area which is about 30 yards away from the tankers. I Rickey Brannon did see the dome lid open when Joey feel, he feel over the dome lid at that point Suzi ask me if I knew C.P.R. I told her no she Ram and got Brian I ran I the fork lift to help Joey down. Where I returned with the lift Brian was on the tank with Joey performing C.P.R. About 10 min later the parametric areaved.

Ricky H. Branne Cy

Re: Joey Sutter

On December 18, 2008 at approximately 2:00 pm, Joey and I went to sample trailer 267. I went up the ladder and vented off the valve to relive pressure in the tank. After the pressure was released, Joey climbed up the ladder to show me how to open up the dome lid. Still on the ladder, he started to undo the wing nuts and then he passed out. I held onto to Joey trying to keep him from falling off the ladder. He gasped two times and started bleeding out his nose. I then, screamed for help. I pulled Joey's body on top of the trailer as far as I could. The security guard called someone on the radio and hollered for help. Brad Wood and the security guard came over to the trailer to assist. I then climbed down the trailer and 911 was called.

Suzi Mock

Duz mode

ZOLL Medical Corporation

Resorder P/N: \$200-6300

Shevard Edwards Joey Dutter brundent -I were returning to the plentrubile entering the plant, Kurry Resse calked my cell to teel me we had an acmergency in the plant Buen and I were duested by guard Loward a haile with sever people or tup. Brun assembled the fix of Duy Much same down The told me that Juy was unomino, Break & Broad Woods were now in cattendance of July sutter , I asked if either Hun CAR lend answer was no, They know and he could not find file and not heathery Burn whil for how long and Brad FPAHONAON

Regnooded - Abent 5 menute, I fold then they had to do some thest injunious attending with breaking into Joey's months while purchay he's nose closed.

and 5 montes later = tataly

Junt to the hospital and the found found found that July was Dot a Spend sweeth his guid found North Man July had complained of head actes for paveral weeks that Dury that lunch July

EPAHO042001362

she said "I begged hem mit to for back to work" because he was feeling so ills

Devener 12/22/08

Drove up to facility and observexed
MAN Cift at Tank 267 and Sazi,
Brain and Joey (Coying down) on Top
of Tank, Brain appeared to be doing
CPR on Joey, Sazi, Standing over Hem!
I did notice MAN way as being closed;
as Paramedics arrived!

Syn Mathe Clary &
Dec 22, 2009

Statement from Godefroy Gbery

On December, 18 2008 I was in the lab, when Suzy ask me to reach Bo because Joey was not OK. I call Bo on in cell but the call went on is voice mail. I went out and saw Brian and Brad on the top of trailer 267. I went on the top of the trailer to try to help them. At this moment Brian was doing a CPR and one moment they try to lay Joey down on the top of the trailer. Denis at this time tries to come up and we saw the PAFD truck pass. I came down of the trailer to go the road to direct the PAFD truck. But that the security was on 82 and make sign to direct the truck. When they arrived, I just saw them takeover of rescue operation.



At 7:30 a.m. on Thursday December 18th lasked Joey Sutter to train Suzi Mock on sampling trucks. He was informed to train her in the proper method, using proper ppe and following all safety precautions. I told him it would be sometimes today and that I would let him know when.

At aprox. 1:30p.m. I saw that Suzi was not to busy and that Joey did not have a lot going on so I asked Suzi to pull samples on the trailers that we loaded from RV1. She went to get Joey and off to the trailer they went. I was on my way to check on them to review Joey on his training when I got a call from Mike about the waste water pump. I went to check on it. About 5 minutes went by when I received a call from Suzi asking me to come help give CPR. I immediately ran to trailer 267 to see what was going on. Once I got there I noticed Brian and brad pe4rforming CPR.

EPAHO042001366

Approximately 14:00

I was in the disporter of fixe I heard the security guard say something across the radio . I relayed buck for him to repeat what he said. He said he needed help out here that Jogg had is ust foesed out on top of tri 267 and Suzi was tolding on to him. I immediately ran out the door and to where the treiler was on line. I dimbed up the ladder. Suzi smid he was bleeding from the nose. I got on top of the trailer Osigniad I torry Joey was laying over the dome lid. I then noticed a little blood on the clome lied and his nose. I started calling his name and shaking him. I got no response? I told Suzi We needed to off but, cooled. roll him over and we did asgentley as we could. I notice he was completely limp 84ill calling his mand, gently shaking him, and gently slapping his force on the cheek trying to get him to come around. Juzi spid we needed to got him off the trailer I replied there was no way the two of us could accomplish that! I continued to calle his name and try to arouse him. I checked for a pulse he

Fushing on his Chest to try and make him start

breathing while at the same time holding his

head and supporting his neck.

.. had one (checkdis wrist) I then treet began

I did notice

G.Smell of

to be Hos and cools

trayor eral Sounded

tilce on the monitor going

hot see the

I noticed Brian weathers driving in the gode and began waving my arm to get his attention He drove up climbed up, and began to try and revive him. Brian and & graphed Joey under his arms and pulled him out of the crash box and, on to the walk way on topof the trailer . atth I checked his pulse again he still had a pulse Brian began to do CPR on Joey while I supported his head and about kept checking for a pulse. In guessing that maspen of Sorb minutes had passed from the time Brian got on top of the trailer and EMS arrived. EMS personal climbed on top of trl. and began working on Josey. The company took lift got the tri with a pallet lifted the pullet to the top. I got on the pullet and was lowered to the ground Bythis time the JLE manlift was there. I moved the forklift out of the way and watched EMS person el continue to worldand give Josy CPR.

Buen Setthers

Incident report for Joey Sutter

Brian Weathers - Manager

Around 2:00 pm, I entered the main gate and was flagged by the security guard to let me know that Joey had passed out and was on top of a trailer. I ran to the trailer when I found Suzi Mock, Brad Wood, and Brent Sittig on top of the trailer assisting Joey. Suzi came down and I went up. Brad was behind Joey holding him in the upright position, tryng to get a response and checking his pulse. Joey had been bleeding from the nose. I asked Brad how long he had been up there and he said approx. 5 minutes. We immediately moved him to a flat section of catwalk on the trailer and began CPR. In between that time Dennis Shaddix came up, and Brent Sittig went down. Dennis monitored his pulse and Brad kept his head stabilized. We administered CPR for about 5 minutes until the EMT personnel arrived and took over. We then shifted Joey onto a board and the paramedics moved him to the ambulance and then the Hospital.

Dec. 22, 2,008 On Dec. 18, 2008 I was parking the truck of trails and had finish parking when i noticed the society quark harrying towards the row of parked trailers first them i saw Brod also hirrying the see what had happen. I went over to see what had happen



Claim Number:

99J0000556027

Notification Date: 12/19/2008

EMPLOYER'S FIRST REPORT OF INJURY

INJURED EMPLOYEE

SSN:

Name: <u>IOFY SUTTER</u> XXX-XX(b)

Mailing

Address: TX

County: Physical Address:

County:

Home Phone: Date of Birth: Marital Status: Not Married

Gender:

Male

Dependents: 00

Language: English

MEDICAL PROVIDER

Fax:

Name:

Tax ID: Address:

Phone:

ATTORNEY

Represented by Attorney:

Name:

Phone:

BUSINESS/EMPLOYER

Name: CESENVIRONMENTAL SERVICES I

0001086044

Address:

4904 GRIGGS RD

HOUSTON TX 77021-3208

Phone: (713)676-1460 Ext:

Fax: (713)676-1676

State: TX

Policy Number:

FEIN: 760592985

Location ID:

EMPLOYMENT

Occupation: WAREHOUSE

Hire Date: 00/00/0000

Partner/Officer/Owner:

No Date Lost Time Began: 00/00/0000 Return to Work Date: 90/00/0000

Last Paycheck was:

Wage: Frequency:

Hours/Week:

Period Start: 00/00/0000

Days/Week: Period End: 00/00/0000

Supervisor Name:

Phone:

Ext:

PREPARER OF REPORT

Name: CHAD

Phone: (713)966-1796

Fax:

Email: mmoser@cesenvironmental.com

Address Where Injury Occurred:

INJURY INFORMATION

Date of Injury: 12/18/2008

Time: 14:30

MISCELLANEOUS, NOC

UNKNOWN/ NOT

Date Reported: 12/18/2008

Nature of Injury: UNKNOWN/NOT REPORTED

REPORTED

Cause of Injury: MISC. CAUSES-OTHER

PORT ARTHUR TX 77640-4541

County: JEFFERSON

2420 GULFWAY DR

Witnesses:

Name:

Phone:

Name:

Phone:

Fatality: Yes

Part of Body:

Name:

Phone:

How and Why the Injury/Illness Occurred

FATALITY. EE WAS CLIMBING ON A TRUCK TO HELP IN THE CHEMICAL VENTING PROCESS. EE STARTED BLEEDING FROM HIS NOSE AND FAINTED. EE PASSED DUE TO ANEURYSM.



INCIDENT REPORT

Near Miss

Accident

Date of Incident 12-18-08 Time $\sim 2:00$ p. m.

Result of Incident: Fatality

1) □Fire
2) □ Explosion 3) Equipment Damage
4) Property Damage
5) □ Product Loss
6) Production Loss 7) Employee Endangerment

8) XX Other FATALITY

Person(s) Directly Involved

Name: Joey Sutter, Suzi Mock, Brad Wood, Krissy Reese, Brian Weathers

Exact Location Where Incident Occurred: 2420 S. Gulfway Dr., Port Arthur, TX 77640, Tanker Line/Unit 267

Investigative Process: Karl A. Guidry, HSE Manager was notified and informed of the incident. Upon arrival at the scene, the area around the proximity of Tanker Unit 267 was immediately roped off with yellow barricade tape. Witnesses were identified and directed to provide written statements while the information was still fresh in their minds. Witness statements are included and are part of this investigative report.

Once notice of the death of Joey Sutter had been made to Karl Guidry, he contacted OSHA at 1-800-321-6742 at ~6:04 PM Central Time to notify them of the fatality in accordance with the provisions of 29 CFR 1904.39 which requires notification in case of death or hospitalization of three or more employees within eight (8) hours of the incident. Notification was in compliance with the requirements of the 29 CFR 1904.39 OSHA Standard. Information provided to the recording notification system by Karl Guidry include a brief statement outlining the purpose of the notification, the name and address of Port Arthur Chemical & Environmental Services and the following personal information regarding Joey Sutter:

1. Name: Joey Sutter

2. Address: (b) (4)



Sequence of Events

Witness statements indicate normal tanker sampling operations were in process and Joey Sutter was training a fellow employee, Suzi Mock on proper sampling techniques. The two individuals had sampled one tanker and proceeded to sample Tanker Unit 267. Witness statements indicate Suzi Mock accessed Tanker Unit 267 first and was situated atop Tanker Unit 267, where she opened one ventilation isolation valve. At this point, Joey Sutter climbed up the ladder to Tanker Unit 267 to continue his training of Suzi Mock. While still on the ladder, Joey Sutter began to loosen the wing nuts on the dome lid of Tanker Unit 267 when according to Suzi Mock, he gasped two times and began to bleed from his nose. Suzi Mock called for help and attempted to pull Joey Sutter's body on top of Tanker Unit 267 with her. Security notified Brad Wood, a fellow employee who instructed Administrative Assistant Krissy Reese to contact 911. Brad Wood proceeded to Tanker Unit 267 and assisted Suzi Mock and began performing CPR on Joey Sutter. 911 personnel arrived on site at ~ 2:19 pm, some ten minutes after being notified. Port Arthur EMT personnel climbed on top of Tanker Unit 267 and relieved facility personnel of CPR duties. Port Arthur Fire Captain Peake directed resources necessary for the removal of Joey Sutter from the top of the tanker.

A facility employee informed Port Arthur Fire Department personnel of the possibility Joey Sutter may have been exposed to toxic fumes. Port Arthur Fire Department personnel lowered Joey Sutter to the ground and transported him to Christus St. Mary's Hospital, located at 3600 Gates Blvd in Port Arthur, Texas. An MSDS was provided to Port Arthur Fire Department personnel indicating the material contents in Tanker Unit 267 was sulfurized isobutylene. (Document attached)

Hospital personnel indicated the presence of a strong odor from Joey Sutter's clothes. Hospital personnel removed the clothes and placed them in a biohazard bag. Christus St. Mary's Hospital staff performed a hazmat wash on Joey Sutter. Port Arthur Fire Department personnel placed a meter in the biohazard bag with Joey Sutter's clothes and recorded the following readings;

- Lel 0
- H2S 0
- CO 0
- 02 20.9%

Describe Fully How Incident Occurred: See witness statements below.

Statement from Suzi Mock: December 18, 2008

Re: Joey Sutter

On December 18, 2008 at approximately 2:00 pm, Joey and I went to sample trailer 267. I went up the ladder and vented off the valve to relive pressure in the tank. After the pressure was released, Joey climbed up the ladder to show me how to open up the dome lid. Still on the ladder, he started to undo the wing nuts and then he passed out. I held onto to Joey trying to keep him from falling off the ladder. He gasped two times and started bleeding out his nose. I then, screamed for help. I pulled Joey's body on top of the trailer as far as I could. The security guard called someone on the radio and hollered for help. Brad Wood and the security guard came over to the trailer to assist. I then climbed down the trailer and 911 was called.

Suzi Mock

713-859-6938

Statement from Krissy Reese December 18, 2009

Re: Joey Sutter

I was sitting at my desk when Brad Wood hurried past my desk and told me to call 911. I then tried to call 911 from my desk phone. It would not dial out due to "IP ADDRESS" (internet down) displayed on the phone. I then grabbed my cell phone and called 911. The call was placed at 2:09 pm. Port Arthur Fire department arrived on scene at 2:19 pm.

Statement from Brad Wood:

12/18/08 Approximately 14:00

I was in the dispatch office I heard the security guard say something across the radio. I relayed back for him to repeat what he said. He said he needed help out here that Joey had just passed out on top of trailer 267 and Suzi was holding onto him. I immediately ran out the door and to where the trailer was on line.

I climbed up the ladder. Suzi said he was bleeding from the nose. I got on top of the trailer Joey was laying over the dome lid. I then noticed a little blood on the dome lid and his nose. I started calling his name and shaking him. I got no response.

I told Suzi we needed to roll him over and we did as gently as we could. I noticed he was completely limp. Still calling his name; gently shaking him; and gently slapping his face



Patriot Security EOC Proudest Employee Owned Company In TEXAS!

INCIDENT REPORT

| DATE: | TIME: AM CONTROL OF THE CONTROL OF T |
|---------------------------------|--|
| POST: Ex. Beaumont Enterprise | LOCATION Ex. 2" Floor Company |
| SECURITY OFFICERS NAME (PRINT): | POLICE DEPARTMENT: Bx. Beaumont PD |
| WITNESS: | AMBULANCE, Ex. Priority. One |
| WINESS: | FIRE DEPARTMENT, Ex. Beattmont FD |

PRINT INCIDENT DETAILS IN ALL CAPITAL LETTERS
COMPLETE INCIDENT DRAWING ON BACK

| BY BPPROL 2:03 I WEERD B CALL FOR PLEID. PLESON |
|---|
| CALLING FOR SIGLP WAS SUZI MOCH CES EMPLOYEE ON JOP |
| OF TRAILER SANK \$267 WITH JOHN SUTTEN CAS EMPLOYER |
| JOBY SUTTEN WAS 1945SED-OUT GUTGE OF TANK |
| T RAN TO TANK FROM SCALE BULDING CALLING ON |
| MADIO FOR HELD. BRED WOOD CKS ENDLOYER BUSERED |
| BUSWERED CALL FOR HELP BURRIUNG AT SITE WITH-IN |
| A MAN. OFFICE MANAGAA K. PEESE COLLED 911 DE |
| Of APPRIX - 2:04 PM. OF BRERY: 3:20 PERT |
| ATTHUR F/D ARPINED. S/S JAMES ON SITE TO |
| ASSIST. CALLES OFFICE OF REPORT. PROBLEW. BY APPROX |
| D' DU STAT CARE AMBUCAUCE ARRIVED ON SITE |
| PORT ANTHUR FID AND CES EMPLOYERS HELP BRING |
| Josey SUTTEN BER JOP OF TANK 2:38 STAT CASE |
| AMBULANCE LEST SITE WITH JOEY SUTTEN ON BOARD |
| PERUT MANAGER KAL AMDERSON & OPERATION SUPER DISOR |
| BRIGHT WENTIMENG WALLED BY APPROX 2:15 BS THEY RETURNED |
| FROM LUNCH |

Security Officer's Signature: Employee # /00

Confidential and Proprietary Patriot Security EOC

Proudest Employee Owned Company In TEXAS!

EPAHO042001375

| Juling Joly of Juent got him down to paramedico u | E D was wolking through when I witnessed Dunie passed out on the troke, the forklift to help get By time I got leach the were on the scene and had |
|--|---|
| Laken over | Anthony SAVOY JA-22-08 |
| | |
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| | |

| AND HE SAID AS OF THIS |
|------------------------------|
| MOMENTO |
| THEY TALKED ABOUT, AT LEAST, |
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| KIDS WELFARE, I YOU THEN |
| TO TALK TO RAMIZ (AEIG |
| THEIR LANDFORD IN the APT. |
| - THEY RENT) |
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| THE FAMILY GYAYED THAT WERE |
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| OUT AT WAKE, AND THE NOW- |
| RESPONSE TIME IN THE |
| - THERHI EXPENSES. STRE |
| THE IS ASKING FOR MUTO DEY |
| REPORT AS SOON AS AVAILS |
| - YOMEDICAL EXAMINER |
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We left around 1 Seen only Persy along with MIKE FROM PIA. (NOT M. BALCH) AT WORK WERT DAY, SAMME AND MIKE WERE STILL VERY ANGRY AND SAYING I Should do what There KNOW the truth, NOT ME, AND LEST ROOM. Couple days Later Received Call from family STATING PAICEV AUD Another Derson, Name Nor MENTINED. OASSED POUD THEM TO REPORT. HE TOLD ME BY TIME THEY WERE GOING TO LET HIM REST IN FACE PENCE, FEARD GOOD DECAUSE AT 15 FACIL Choice, He, then, TOWN ME they have NOT RECEIVED THE EXPENSES FROM CES , as OF RECENT DAYE BND WAS NOT VERY PLEASED ACCORDING TO WHAT KAMIZ HAPPY SIFHER, HE, a/50, SAID HE WAS YOUD TO BE SMAKET AND NOT LOT THIS MATTER DROP WITHOUT A GOLD BANCE, I

YOUD AIM THAY HIS MOM, also

WISHED TO LET IT REST

EPAHO042001378

STATED MAY CES WAS DAYING or All fuveral awaygenesses MID JUSURANCE MONEY FOR TOUNS KIDS O WHAT EVER THE POLICY COVERS, CES WILL COVER to questions asked I traveled to family youse AND TALKED TO THEM, THEY SAI AGAIN, RAMIZ RE-STAYED. JOEVS ANURISM AND CO COVER All OXDENSES ... them to let the KNOW Times of Wake - then left a later weighter ther emiled with times france AND MYSEL fuveral AND VIEWED JOE ONTHE WAY, RICKEY CASSED SND SAID HIM, PERFY W., AND OTHERS At funeral the DAD SHOWED ME A CARD FROM GREGG LAWRENCE AND ASKED WHO HE WAS, ITON hin I don't KNOW, So he fore the card in half pur threw It WE Sig NEXT TO BAMIZ AND HIS WIFE AND HE TOUD ME ABOUT COUTRING EXPONSES, I

that he taked 28, KARL GUIDRY, Fred AND WAS LAST -OFF With Day West farther cotice THEN , he said again, some body should do what is right for the family = I told thin, again, that not being there if twould MIKE TOUD ME AT NEXT DAYS WORK THAT RICKLY GUZI, FAMMIE) AND HIM WERE TAIKING ABOUT WHAT THEY THINK "1 THE RIGHT THING TO DO, I TON him THAY I AM NOT INVOLUTED even being friends with family, because I WAS NOT THERET AND ONLY HEARD HERE-GAYS THEY GOT MAD AT ME, AND SALD I WAS VERY WRONG TOR NOT SETTING INVOLVED. SAMME vas so upset, she left work, AND MIKE LETT NOT TOO LONG AFTER WARDS. THE FAMILY CALLED ME, AND SALD move up HE RECEIVED CALL FROM RICKEY STATING, WHAT HE SHID, WAS THE 10 TRUE VERSION OF INCIDENT AND arrow NOT WHAT MR. RAMIZ MARCHAN Then of as privarian. He, then according to DAD

HE ASKED FOR PARENTS THINE NUMBER TO JAY 715-CONDO/ENCES = IGAVETY TO SECONDS LAYER, KECETUR TRUTH OF THE EVENTS I AND IF HE KUEW WHAT WAS RIGHT SHOWED CALL Speak, because A

THE WAS THEN INFORMED TO leave THEMISES - SO BE DICKED UP 1715 TOOLS PAID READED DOCK TO HOUSTON (D. CO. UN) WHILE ON THE ROAD, HE RECALED BND STATED THAT SUZI HAD
CASSED TERRIFIED, DECAUSE
BRIAN AND BO FORKED TO HER
ABOUT THE STAND SEGUENCE OF EUENTS. THEY TOLD HER, HE COULDED HAVE, HAD BEEN INTLUENCED BY HOS DUE TO UD SHUT TOO TIGHT AND VENT NOT DROPERTY -----OPENED ____ MIKE TOUT ME THAT HE TOWN HER TO STICK WITH HERE _____ TERSION AND TO NOT ATTE A55055MENTS ----We censed to TALK DUE TO WOOMING CAN ON MIKE 5 THOUTE (SAID HE WOULD CALL BACK, LATER) & DID NOT? - - -_____ LATER, RECEIVED CALL FROM MIKE'S FIFONE = CALLER WAS EICKEY BANNON

The state of the s

RECEIVED CALL FROM MIKE BALOH FROM P.A. STATING HEWAS YOUD BY SUZI) NASO EMPLOYEE, THAT 13 WAS VOEY GUTTER SUZI INFORMED MIKE THAT JOEY AND HER ON ATAUKS SHE SCREAMED DUTTONO AVAIL = SINALL, The es in they teams I She Gast the was bleeding

Joey Suttez

Advanced Toxicology Network 4900 Outland Center Drive Ste 103 MEMPHIS, TN 38118 (888) 290-1150

UDS Result Form

Result Information

CMC - Houston I-10 East Center: Address : 10909 East Frwy Houston, TX 77029 City:

Attn: CMC/TX-HOUSTON I-10 EAST

Patient Name: Patient SSN:

Profile : RUG SCREEN: 10 PANEL

Reason: Pre-Employment

Rejection:

Date Collected: 08/20/2008 Time: 9:42 AM Date Received: 08/21/2008 1:25 AM Time:

Time: 2:50 AM Date Reported: 08/21/2008

Creatinine: Ph:

Specific Gray:

Specimen ID:

Result:

Status :

Sub Acct :

Location:

| Screened Summary | | | | |
|------------------|-------------|---------------|--|--|
| Drug | Cutoff/GCMS | Cutoff/Screen | | |
| Amphetamine | 500 | 1000 | | |
| Barbiturates | 200 | 300 | | |
| Benzodiazepines | 200 | 300 | | |
| Benzoyleogonine | 150 | 300 | | |
| Carboxy-THC | 15 | 50 | | |
| Methadone | 200 | 300 | | |
| Methaqualone | 200 | 300 | | |
| Opiates | 2000 | 2000 | | |
| Propoxyphene | 200 | 300 | | |
| Phencyclidine | 25 | 25 | | |

Comment Summary

316666032

NEGATIVE

Reported

NDOT

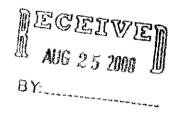
Contact Name: Prabhakar Thangudu

Mail Address: 4904 Griggs Rd

CES Environmental

HOUSTON,TX 77021

Comment



Result Summary

Janet Putnam, Lab Director

Service Date: 08/20/2008

Concentra Medical Centers 10909 East Frwy Houston, TX 77029 Phone: (713) 973-7943 Fax: (713) 973-7947 Physical Exam

| Name: (b) (4) | | SSN: 401 | -08-2362 | Date: 08/20/2008 |
|-------------------|----------------|--|------------------|---------------------------------|
| PHYSICAL EXAM | 1 Diolo | | | |
| Height We | ight: Zer | Cemperature: | | 1 |
| B/P Resting | Pulse XV | Repeat B/P, | | 30 Near Rt Rt 80 o |
| (2 min of ex) | Pulse | | Lt <u>20</u> | |
| Respirations/min_ | 14 | | Distant Rt 20 | |
| Hearing to forced | whisper @ 5 fe | eet R | Lt. <u>20</u> | (6 Lt Pepth)Perception |
| | | LIAIL | | (NL AB |
| | | <u>Heart</u> | | Reflexes |
| HEENT | | Rhythm | NL AB | Babinski ME AB |
| Eyes | | Auscultation | NL AB | Romberg (NEG POS |
| Globe | NL AB | Abdomen | NL AB | Pupillary Rt (Ni⊾ AB |
| Pupils | NL AB | Abd. surg. scar | NY | Lt (NL)AB |
| EOM's | NI AB | <u>Hernia</u> | | Accom. Rt NL AB |
| Funduscopic | NL AB | Umbilical | NY | Lt (NL) AB |
| Ocular Pressur | e: | Inguinal | NY | Biceps Rt (NL) AB |
| Rt | NL AB | Femoral | NY | Lt NL AB |
| Lt | NL AB | Varicocele | NY | Knee Rt Nb AB |
| <u>Ears</u> | <u>~1</u> | Upper Extremity | NL AB | Lt (NL AB |
| Canal Clear | YN | Hands/Fingers | NL AB | Ankle Rt NL AB |
| TM Visualized | YN | Legs | NL AB | Lt (NL) AB |
| Scarring of TM | NY | Knees | NL AB | Proprioception |
| Drainage | NY | Knee surg. scar | NY | Up. Ext. Rt NL AB, Lt NL AB |
| Nose | NL AB | Feet/ankles | NL AB | Low. Ext. Rt NL AB |
| Mouth | | Varicosities | NL AB | Lt ML AB |
| Teeth | NH AB | Up. ext. strength | NL AB | Sensory Examination: |
| Throat Skin | NL AB | Up. ext. ROM | NL AB | Up. Ext. Rt NL AB |
| Neck | NL AB | Low, ext. strength | NL AB | Lt NL\AB |
| Thyroid | NL AB | Low. ext. ROM | NL AB NL AB | Low. Ext. Rt \ NL \AB |
| Chest Wall | NL AB | Back/spine ROM Back surg. scar | NY | Lt NL AB |
| Lungs | NL AB | Neurological Exam | 1 · 1 | OPTIONAL: |
| 201.90 | | Cran. nerves 2-12: | 1 1 | Genitalia NL AB Breast NL AB |
| Comments: | | Grant, Herves 2-12. | 10 AB | Rectal NL/AB |
| | | | | Trocker Transfer |
| ANCILLARY STU | DIES to | 03 1 ~ | . [75 | t Oc |
| Urinalysis Spec. | 4 20 4 | Albumin New Si | ugar Held Blo | od NES |
| EKG | N/A NL / | | HPE | NL AB |
| Comments: | | ************************************** | Comments: | |
| Lumbar X-Ray | N/A NL A | AB See Results | Dellas and a Com | ation Took |
| Comments: | IN/A INL / | VD See I/eanita | Pulmonary Fun | FEV1/FVC |
| | | | Respirator Qua | |
| Chest X-Ray | N/A NL A | AB See Results | • | |
| Comments: | | | | |
| Blood Analysis | N/A NL A | AB See Results | Impairment Rat | |
| Comments: | | | Comments: | |
| 00.111101.103 | | | | |
| Audiogram | N/A NL A | AB See Results | | |
| Comments: | | | _ | |

Eval - Pre-Placement

Concentra Medical Centers
10909 East Frwy Houston, TX 77029
Phone: (713) 973-7943 Fax: (713) 973-7947

RESPIRATORY FIT TEST ASSESSMENT RECORD

| Service Date: | 08/20/2008 | | Respirator Type: | | |
|--|-----------------------|--|--|----------------|---|
| Employee Name: | Sutter, Joey | | Respirator Model: | | · |
| Employee SSN: | 401-08-2362 | · · · · · · · · · · · · · · · · · · · | Cartridge Type: | | |
| Employer: | CES Environme | ental | | utes/day | |
| Department: | OLO CITTORIN | | - | rs/day | |
| - Dopariment | | | | s/week | |
| Qualitative Fit Test (Q | LFT) Protocol use | od: | Exercise (each exercise shall be conduct | ted for one m | inute |
| • | • | uipped with an organic vapor filter) | except for grimace which shall be condu | | |
| | • | Model 40 Inhalation Medication | · • | | - · - · · - · · · · · · · · · · · · · · |
| Nebulizer or equivale | ent) | | Breathing | Da | F-14 |
| □Bitrex (Denatonium B | enzoate) Aerosol | | Normal Deep | Pass Pass | Fail Fail |
| Quantitative Fit Test (| QNFT) Protocol us | sed: | Head | Pass | Fail |
| D Test Chamb | er: Circle one of th | e following: | Turn Left | Pass | Fail |
| Corn Oil | | | Turn Right | Pass | Fail |
| Polyethylene glycol 4 | • | | Side: Left | Pass | Fail |
| di-2-ethyl hexyl sebac | ate (DEHS) | | Side: Right | Pass | Fail |
| Sodium Chloride | | | Move Up | Pass | Fail |
| Condensation Nuclei | | | Move Down | Pass | Fail |
| • | • | st 5 minutes prior to assessment | Talking | | |
| Yes No Subject cond | | | Name | Pass | Fail |
| • • | - | ctory fit must be removed or altered. | SSN# | Pass | Fail |
| | • | e fit test and his/her responsibilities | Read | Pass | Fail |
| prior to asses | | quipment during fit test | Rainbow Passage observed by tester | Pass | Fail |
| Yes No Subject wore | | a, NC: Not Comfortable) | Facial Expressions | | |
| | | | Grimace | Pass | Fail |
| | | 7 | Smile | Pass | Fail |
| NC Room for eye NC Room to talk | protection | | Frown | Pass | Fail |
| C NC Position of ma | ask on face and ch | eeks | Body Movement | | |
| Adequacy of the fit (A | | | Bend at waist | Pass | Fail |
| A NA Chin properly | | | Jog in place | Pass | Fail |
| A NA Adequate stra | • | lv tiaht | Subject rates comfort of respirator: 1 2 | 3 4 5 6 | 5 7 8 9 10 |
| A NA Fit across nos | | | Least | | Most |
| A NA Proper size to | - | nose to chin | Yes No Subject made no attempt(s) to adj | ust respirator | during assessmer |
| A NA Tendency of i | | | Assessment (CHECK VALL THAT APPL | V 1 | |
| | | evaluate fit and position. | Test discontinued due to: | , | |
| Physician's Commer | nts | | Hair growth; beard, mustache, sie | deburns which | cross respirator |
| 1 Hysician a common | | | sealing surface. | | · oroco roopiiatoi |
| | | | □ Difficulty breathing, or | | |
| | | | Comfort or Fit of respirator was u | nacceptable t | o employee. |
| | | | Recommendation(s) | | |
| T Class LE | C 75% or more: | FEV1/FVC Ratio 70 % or more (Ref | | | |
| * " | rictions on Respirat | | er to Odigesine Charty | | |
| | | ∪ 036 V1/FVC Ratio 60%-70% of Predicted | (Refer to Guideline Chart) | | |
| Some so | ecific restrictions o | | - (Notes to Generally | | |
| Class III | | V1/FVC Ratio 50%-60% of Predicted | d (Refer to Guideline Chart) | | |
| Respirate | or use not permitte | | , , , | | |
| Further to | seting required: | | | | |
| Subject t | o return after facial | hair is removed for completion of As | ssessment by | | |
| | | | espirator and return for assessment by | | |
| | | | 1. | Λ | |
| 1 Planie | Signature | and and and and and and and and and and | Han | ian's Name | Chama |
| | | | | | |

Print Date: r_resp_fit_test_asses Page 1 of 1

Revision Date

08/20/2008 06/29/1999

Concentra Medical Centers
10909 East Frwy Houston, TX 77029
Phone: (713) 973-7943 Fax: (713) 973-7947

| PLHCP' WRI | TTEN STATEMENT for RESPIRATORS (EMPLOYEE) |
|---|--|
| Service Date: _08/20/2008 | |
| Employee Name: | Employee SSN: (b) (4) |
| Sutter, Joey | |
| Address: | |
| ∆ 125 Ann St | |
| #7.4 | |
| PASADENA TX 7750 | 06 |
| Employer: CES Environmental | |
| You were evaluated in this office of yo | ur medical status related to your physical capability |
| to wear a respirator. (Check \checkmark one that | t applies) |
| | would hamper your ability to perform your job duties while wearing a respirator. ere not related to wearing a respirator but should be reported to your ion. |
| Based upon the results of this evalua | tion it is my opinion that you: (Check ✓ <u>ALL</u> that apply) |
| ARE qualified to wear a respirator. | |
| Have the following restrictions concer | ning respirator usage: |
| ☐ ARE NOT qualified to wear a respirate | |
| | physician who must submit a written report of his/her findings to |
| Concentra Medical Centers | so that a final decision on your ability to wear a respirator can be made |
| Must wear Special prescription eye-w | |
| Must use an Eye glass conversion kit. | |
| ☐ May need to shave Facial hair to assu☐ Need to stop smoking. | ire tight seal on certain face masks. |
| Meed to stop smoking. | |
| (Check ALL that apply) | |
| use only. Employees should be instructed to report an This evaluation included the Respiratory Questionnair. The above individual HAS NOT been examined by m Questionnaire in Appendix C Part A Section 2. In accordance | or fitness in accordance with 29 CFR 1910.134. This limited evaluation is specific to respirator by difficulties in using respirators or change of any physical status to their supervisor or physician. The outlined in 29 CFR 1910.134. The employee's medical evaluation consisted of a review of OSHA's Medical Evaluation or and with 29 CFR 1910.134, this limited evaluation is specific to respirator use only. Employees should be instructed of any physical status to their supervisor or physician. This evaluation included the Respiratory Ouestionnaire |
| In accordance with specific OSHA requirements, I have | re informed the above named individual of the results of this evaluation and of any medical conditions resulting from timent. Where applicable, the above named individual has been informed of the increased risk of tung cancer bestos, lead and/or other chemical exposure(s). |
| and warnings for proper use contained on the respirator (| ainment and concentration levels to which the worker will be exposed. Failure to follow the use and fitting instruction packaging and/or failure to wear the respirator during all times of exposure can reduce the respirator's effectiveness In the proper care of any respirator.Refer to product literature and packaging for specific information regarding fit, |
| PLAGP Signature Jen T. Delma | Employee's Signature |
| Star T. Delman | Expiration Date |
| PLHCP Name (printed) | Expiration Date |
| ¹ Physician or other Licensed Healthcare Professional | |
| To be m | naintained in the employee's file with a copy to the employee |

r_pihcp_stmt_res.p_employee

Page 1 of 1

Print Date:

08/20/2008 Revision Date: 04/06/2000

Concentra Medical Centers

10909 East Frwy Houston, TX 77029 Phone: (713) 973-7943 Fax: (713) 973-7947

EMPLOYER AUTHORIZATION AND INFORMATION FOR RESPIRATORY EVALUATION

| EMPLOYER TO COMPL | ETE THE FOLLOWING: | | ddress: | | |
|---|--|---|--|---|---|
| Employee Name: Sutter, Jo | ey | |) (4) | | |
| | | | 74 | | |
| Employer: CES Environmenta | il | _ | mployee SSN: | 401-08-2362 | <u>, ,</u> |
| Check Type of Respirator(s) | o Be Used (Check ✓ ALL th | at apply) E | xtent of Useage | (Check ✓ ALL tha | at apply) |
| Air-purifying (non-powered) | | | | sis Total Hou | |
| Atmosphere supplying Resi | | | | | twice a week Total Hours |
| Combination air-line and SC | | | | | ns only Total Hours |
| Continous-Flow Respirator | | | | | (Check VALL that apply) |
| Supplied-Air Respirator | _ | <u> </u> | Light | Moderate | Heavy |
| == 0 p a., 0., a., a., a. | LiClosed Circuit SCBA | E | | | (Check ✓ ALL that apply) |
| ☐ Dust Mask ☐ 1/2 Face | | Will Oblisions | | | |
| Make: Mode | : Cartridge: _ | | ∐ Arsenic | | Benzene |
| Special Work Conditions | | | ∐ Coke Oven □ Cadmium | | Cotton Seed / Dust Formaldehyde |
| (Check YALL That Apply Wh | en Wearing Respirator) | | □ Cadmium □ Methylene Ci | | Lead |
| ☐ High Places | ☐ Enclosed Places ☐ Prot | ective Clothing | Textiles | | Chromium |
| Temperature Extremes | ☐Mostly Cold ☐ Mos | tly Hot | | _ | Chroman |
| Other: | | | ther(s): | | |
| Questionare will be: HAN | D CARRIED MAILED | OTHER E | VALUATION AU | THORIZATION BY: | |
| DO NOT WRITE BELOW THIS | LINE | DO NOT WRITE BELO | NA THIS LIME | | gnature of Employer Representative OT WRITE BELOW THIS LINE |
| DO NOT WRITE BELOW THIS | LINE | DO NOT WRITE BELL | AA LUIS CINC | DO NC | ANTIE BELOM THIS TIME |
| First aid and safety personnel ma Based upon my findings, I have de Employee must schedule a medic Class I - No Restrictions on Res Class II - Some Specific Use Re Class III - Respirator Use is NO Further Testing / Evaluation is Re Fit Test Required Fit Test Performed Unsatisfactoril Special prescription eyewear nee Facial hair needs to be shaved to Physician or other Licensed Heal Employee must seek further medic | be informed about necessary restriction be informed, when appropriate, if the etermined that this individual Characteristics cal examination with Concentral pirator Use strictions To be used for I PERMITTED quired, 2 Fit Test Performed S y Fit Test NOT Performed to accommodate respirator assure tight seal on certain face masking | ns on the work or duties of an edisability might require emer- eck ALL (that apply) Medical Centers Emergency Response or Esc Satisfactorily Concentra Me Special prescriptions. | employee and necegency treatment. prior to cape Only edical Center on eyewear needed | essary accommodations or respirator approval and Other: Others of to accommodate resp | d usage. |
| of his/her findings to | | | | | |
| (Check ✓ ALL that apply) | | | | | |
| This evaluation included the Res The above individual HAS NOT Questionnaire in Appendix C Par | examined for respirator fitness in accornistructed to report any difficulties in usibilitation of the control o | ing respirators or change of a FR 1910.134. ness, The employee's medica FR 1910.134, this limited eva | ny physical status to evaluation consistuation is specific to | o their supervisor or phy ed of a review of OSHA Direspirator use only. En | rsician. 's Medical Evaluation nployees would be instructed |
| In accordance with specific OSH, exposures that may require further | A requirements, I have informed the above explanation or treatment. Where app | licable, the above named indi | vidual has been inf | formed of the increased | risk of lung cancer |
| | t of smoking and asbestos, lead and/o | i omei chemical exposure(s), | _ | 10 - | 3.7. |
| Physician's Signature | una ma | ~ | Physicia | n's Name (Prints | (1016-10 pen |
| Physician's Signature | 72-73 | | гну\$кан ₹ - | irs ivallie (milite De ees | 14) f = 7 = AG |
| Physician's License Numb | er (Optional in Most States | - s) | Date of E | <i>Lซ ซX</i> Exam | 1) 0 / 6 - 1 1 1 1 1 1 1 1 1 1 |
| _plhcp_stmt_resp_employer | | age 1 of 1 | · | Print D | |

Concentra Medical Centers 10909 East Frwy Houston, TX 77029 Phone: (713) 973-7943 Fax: (713) 973-7947

Physical Exam

Name: Sutter, Joey



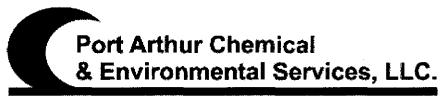
Date: 08/20/2008

Service Date: 08/20/2008

Examination Results

| Able to perform essential functions as listed. |
|--|
| Unable to perform all essential functions as listed. Please list failed essential function(s): |
| |
| No medical restrictions are indicated. |
| No medical restrictions are indicated. |
| The following medical restrictions are indicated: |
| |
| Recommend further evaluation. |
| Remarks: |
| |
| |

Provider Print Name Here



INCIDENT REPORT

Near Miss Accident

Date of Incident 12-18-08 Time ~ 2:00 p. m.

Result of Incident: Fatality

1) □Fire 2) □ Explosion 3) Equipment Damage 4) Property Damage

5) Product Loss 6) Production Loss 7) Employee Endangerment

8) XX Other FATALITY

Person(s) Directly Involved

Name: Joey Sutter, Suzi Mock, Brad Wood, Krissy Reese, Brian Weathers

Exact Location Where Incident Occurred: 2420 S. Gulfway Dr., Port Arthur, TX 77640, Tanker Line/Unit 267

Investigative Process: Karl A. Guidry, HSE Manager was notified and informed of the incident. Upon arrival at the scene, the area around the proximity of Tanker Unit 267 was immediately roped off with yellow barricade tape. Witnesses were identified and directed to provide written statements while the information was still fresh in their minds. Witness statements are included and are part of this investigative report.

Once notice of the death of Joey Sutter had been made to Karl Guidry, he contacted OSHA at 1-800-321-6742 at ~6:04 PM Central Time to notify them of the fatality in accordance with the provisions of 29 CFR 1904.39 which requires notification in case of death or hospitalization of three or more employees within eight (8) hours of the incident. Notification was in compliance with the requirements of the 29 CFR 1904.39 OSHA Standard. Information provided to the recording notification system by Karl Guidry include a brief statement outlining the purpose of the notification, the name and address of Port Arthur Chemical & Environmental Services and the following personal information regarding Joey Sutter:

1. Name: Joey Sutter
2. Address: (b) (4)

3. SSN (b) (4)

4. DOB: (b) (4)

5. Contact info for Karl Guidry, cell phone number (b) (4)

from OSHA's South Region Office would contact Karl Guidry.

An OSHA representative contacted Karl Guidry and verified the information which had been left on the OSHA Notification recording system. The OSHA representative confirmed to Karl Guidry notification of Joey Sutter's death was provided in a timely manner and an OSHA Representative

On Friday, December 19, 2008, Karl Guidry received a call from OSHA Representative Kelly Knighton indicating she would be handling the investigation of the incident regarding the fatality of Joey Sutter. Ms. Knighton requested a copy of the MSDS for the material contents of Tanker Unit 267 along with the placard which was on Tanker Unit 267. Karl Guidry contacted Krissy Reese and instructed her to scan and e-mail the documents to Ms. Knighton at Krissy Reese confirmed sending the documents and Ms. Knighton confirmed receipt of the documents. (Hard copy of documents attached)

Ms. Knighton also requested copies of the manifest for the contents of Tanker Unit 267. Karl Guidry contacted Dispatch and requested any and all documents related to Tanker Unit 267 and its contents be faxed to Ms. Knighton at fax number 281-286-6352. A total of eleven (11) manifests which made up the composite load of Tanker Unit 267 were confirmed faxed to Ms. Knighton at the above referenced fax number. (Hard copy of documents are attached)

Karl Guidry proceeded to the Port Arthur Fire Department and obtained a copy of the incident report to be attached and made part of this investigative report of the sequence of events surrounding the circumstances of this matter. (A hard copy of Port Arthur Fire Department Incident Report # 08-0012882 is attached)

Karl Guidry contacted the Jefferson County Coroner's Office whose address is 5030 Highway 69 S Ste 700, Beaumont. (409) 726-2571 and was informed the autopsy report for Joey Sutter would be ready Tuesday, December 23, 2008. No other details or findings were communicated to Karl Guidry as of the writing of this investigative report.

Sequence of Events

Witness statements indicate normal tanker sampling operations were in process and Joey Sutter was training a fellow employee, Suzi Mock on proper sampling techniques. The two individuals had sampled one tanker and proceeded to sample Tanker Unit 267. Witness statements indicate Suzi Mock accessed Tanker Unit 267 first and was situated atop Tanker Unit 267, where she opened one ventilation isolation valve. At this point, Joey Sutter climbed up the ladder to Tanker Unit 267 to continue his training of Suzi Mock. While still on the ladder, Joey Sutter began to loosen the wing nuts on the dome lid of Tanker Unit 267 when according to Suzi Mock, he gasped two times and began to bleed from his nose. Suzi Mock called for help and attempted to pull Joey Sutter's body on top of Tanker Unit 267 with her. Security notified Brad Wood, a fellow employee who instructed Administrative Assistant Krissy Reese to contact 911. Brad Wood proceeded to Tanker Unit 267 and assisted Suzi Mock and began performing CPR on Joey Sutter. 911 personnel arrived on site at ~ 2:19 pm, some ten minutes after being notified. Port Arthur EMT personnel climbed on top of Tanker Unit 267 and relieved facility personnel of CPR duties. Port Arthur Fire Captain Peake directed resources necessary for the removal of Joey Sutter from the top of the tanker.

A facility employee informed Port Arthur Fire Department personnel of the possibility Joey Sutter may have been exposed to toxic fumes. Port Arthur Fire Department personnel lowered Joey Sutter to the ground and transported him to Christus St. Mary's Hospital, located at 3600 Gates Blvd in Port Arthur, Texas. An MSDS was provided to Port Arthur Fire Department personnel indicating the material contents in Tanker Unit 267 was sulfurized isobutylene. (Document attached)

Hospital personnel indicated the presence of a strong odor from Joey Sutter's clothes. Hospital personnel removed the clothes and placed them in a biohazard bag. Christus St. Mary's Hospital staff performed a hazmat wash on Joey Sutter. Port Arthur Fire Department personnel placed a meter in the biohazard bag with Joey Sutter's clothes and recorded the following readings;

- Lel 0
- H2S 0
- CO 0
- 02 20.9%

Port Arthur Fire Department personnel donned scrubs supplied by the hospital and were able to remove their clothing and shower as a precaution of handling Joey Sutter. Two other Port Arthur Fire Department personnel donned Class "B" suits and air packs and assisted with placing Joey Sutter's body into two body bags prior to being released to the morgue for autopsy. Joey Sutter's clothing and the Class "B" suits used by Port Arthur Fire Department were also sent to the morgue.

Port Arthur Fire Department personnel returned to the facility to perform Draeger readings on Tanker Unit 267. Draeger readings indicated a 1PPM H2S result.

A visual inspection was made of the Unit 267 Tanker to determine if any unknown contributing factors may have been present. The tanker ventilation and depressurization system was inspected and found to be in complete isolation less the one valve on top of the Tanker Unit 267, which had been opened by Suzi Mock as part of her training. The tanker ventilation and depressurization system is flex piped to release pressure at ground level while personnel access the crash box /dome lid area of the tanker. This method insures adequate safety for facility personnel from possible overpressure of tankers being sampled. The inspection revealed the Tanker Unit 267 was not actually vented due to the fact Suzi Mock was being trained by Joey Sutter and had not actually opened the ground level valve (second isolation valve) on the ventilation and depressurization system.

During interviews with facility personnel, one employee conveyed that he had been informed by a Port Arthur Fire Department employee at the scene assisting with Joey Sutter the following: "based on the fact Joey had nose bleed and his body was blue from the chest up indicated some sort of aneurism or possible heart attack."

Describe Fully How Incident Occurred: See witness statements below.

Statement from Suzi Mock: December 18, 2008

Re: Joey Sutter

On December 18, 2008 at approximately 2:00 pm, Joey and I went to sample trailer 267. I went up the ladder and vented off the valve to relive pressure in the tank. After the pressure was released, Joey climbed up the ladder to show me how to open up the dome lid. Still on the ladder, he started to undo the wing nuts and then he passed out. I held onto to Joey trying to keep him from falling off the ladder. He gasped two times and started bleeding out his nose. I then, screamed for help. I pulled Joey's body on top of the trailer as far as I could. The security guard called someone on the radio and hollered for help. Brad Wood and the security guard came over to the trailer to assist. I then climbed down the trailer and 911 was called.

Suzi Mock



Statement from Krissy Reese December 18, 2009

Re: Joey Sutter

I was sitting at my desk when Brad Wood hurried past my desk and told me to call 911. I then tried to call 911 from my desk phone. It would not dial out due to "IP ADDRESS" (internet down) displayed on the phone. I then grabbed my cell phone and called 911. The call was placed at 2:09 pm. Port Arthur Fire department arrived on scene at 2:19 pm.

Statement from Brad Wood:

12/18/08 Approximately 14:00

I was in the dispatch office I heard the security guard say something across the radio. I relayed back for him to repeat what he said. He said he needed help out here that Joey had just passed out on top of trailer 267 and Suzi was holding onto him. I immediately ran out the door and to where the trailer was on line.

I climbed up the ladder. Suzi said he was bleeding from the nose. I got on top of the trailer Joey was laying over the dome lid. I then noticed a little blood on the dome lid and his nose. I started calling his name and shaking him. I got no response.

I told Suzi we needed to roll him over and we did as gently as we could. I noticed he was completely limp. Still calling his name; gently shaking him; and gently slapping his face

on the cheek trying to get him to come around. Suzi said we needed to get him off the trailer, I replied there was no way the two of us could accomplish that. I continued to call his name and try to arouse him. I checked for a pulse, he had one (checking his wrist). I then began pushing on his chest to try and make him start breathing while at the same time holding his head and supporting his neck.

I noticed Brian Weathers driving in the gate and began waving my arm to get his attention. He drove up and climbed up. Suzi at this point went down off the trailer.

Brain began to try and revive him. Brian and I grabbed Joey under his arms and pulled him out of the crash box and onto the walkway on top of the trailer. I checked his pulse again, he still had a pulse. Brian began to do CPR on Joey while I supported his head and kept checking for a pulse.

Dennis at this point was at the scene, said he knew CPR and climbed on top to assist me and Brain by holding Joey's hand and talking to Joey. I'm guessing that a span of 5 or 6 minutes had passed from the time Brian got on top of the trailer and EMS arrived.

EMS personnel climbed on top of the trailer and began working on Joey. The company forklift got to the trailer with a pallet and lifted the pallet to the top. I got on the pallet and was lowered to the ground. By this time the JLG man lift was there. I moved the forklift out of the way and watched EMS personnel continue to work on and give Joey CPR.

What Unsafe Acts/Conditions Lead to Incident: There were no unsafe acts involved. It appears this incident was the result of a personal medical condition.

Recommendations to Prevent Reoccurrence: There are no recommendations to prevent recurrence since this incident was not job related.

Preliminary Assumptions:

| Prepared by: insert name | Title: insert | Initials |
|---------------------------|---------------|----------|
| Approved by: insert spysr | Title: insert | Initials |



Port Arthur Fire Department Haz-Mat Sampling Tanker Unit 267 (Close-up)

See Port Arthur Fire Department Incident Report # 08-0012882 Page 3 HR-1 Supplement
Indicating Draeger Read of 1 ppm of H2S (Incident Report Attached)



Port Arthur Fire Department Haz-Mat Sampling Tanker Unit 267 (Farther Away)

See Port Arthur Fire Department Incident Report # 08-0012882 Page 3 HR-1 Supplement
Indicating Draeger Read of 1 ppm of H2S (Incident Report Attached)



12/19/2008

C E S ENVIRONMENTAL SERVICES I 4904 GRIGGS RD HOUSTON TX 77021-3208 mmoser@cesenvironmental.com

Notification Confirming Receipt of Claim

Date of Injury:

Injured Worker: Claim Number:

Policy Number:

12/18/2008 SUTTER JOEY

0001086044

Attached is a copy of the information you reported to Texas Mutual Insurance Company which was used to establish this claim. You may submit additional claim information to Texas Mutual Insurance Company. If you have questions regarding this report of injury please contact us at (800) 859-5995.

If your policy includes our workers' compensation health care network option you are required by law to obtain a second Employee Acknowledgement of Workers' Compensation Network Form signed by the injured worker. Please submit a copy of the signed, second acknowledgement form to Texas Mutual Insurance Company. You can find a copy of the form online at www.texasmutual.com/hcn/hcn.shtm

Below please find information that will help you through the claim process:

To submit additional claim information:

Mail to: P. O. Box 12029 Austin, Texas 78711-2029

Fax to: (512) 224-3889

To locate a treating doctor:

www.texasmutual.com/workers/iwADL.shtm

To contact the handling adjuster:

Call: (800) 859-5995

Monday - Friday; 8:00 a.m. - 5:30 p.m.

To obtain a copy of the Employer and Employee Rights and Responsibilities in the

Workers' Compensation System:

www.texasmutual.com/employers/erRights.shtm

To locate a pharmacy, or for pharmacy questions, contact Scripnet:

Call: (888) 880-8562 www.scripnet.com

To obtain a copy of the Employer and Employee Rights and Responsibilities for the workers' comp health care network:

www.texasmutual.com/hcn/hcn.shtm

Additional Texas Mutual® online services at www.texasmutual.com, available 6 a.m. - 9 p.m., include:

- o Obtain logon id, or for immediate logon id, call (800) 859-5995, M-F, 8:00 a.m. 5:30 p.m.
- Submit first report of injury in the Employers section
- Submit wage statement when reviewing loss runs and claim details
- Obtain specific claim summary information



Claim Number:

99J0000556027

Notification Date: 12/19/2008

EMPLOYER'S FIRST REPORT OF INJURY

INJURED EMPLOYEE

Name: SSN:

JOEY SUTTER XXX-XX

Mailing

Address: TX

County: Physical Address:

County:

Home Phone:

Date of Birth: (b) Marital Status: Not Married

Gender: Language: Male

Dependents: 00

Fax:

English

MEDICAL PROVIDER

Name:

Tax ID: Address:

Phone:

ATTORNEY

Represented by Attorney:

Name:

Part of Body:

Fatality:

Phone:

BUSINESS/EMPLOYER

Name: CESENVIRONMENTAL SERVICES I

Address:

4904 GRIGGS RD

HOUSTON TX 77021-3208

Phone: (713)676-1460 Ext:

Fax: (713)676-1676

Policy Number:

0001086044 760592985

FEIN: Location ID:

EMPLOYMENT

No

Occupation: WAREHOUSE

Hire Date: 00/00/0000

Partner/Officer/Owner:

Date Lost Time Began: Return to Work Date:

00/00/0000 00/00/0000

State: TX

Last Paycheck was:

Wage: Frequency:

Hours/Week:

Davs/Week:

Period Start: 00/00/0000

Period End: 00/00/0000

Supervisor Name:

Phone:

Ext:

PREPARER OF REPORT

Name: CHAD

Phone: (713)966-1796

Ext:

Fax:

Email: mmoser@cesenvironmental.com

INJURY INFORMATION

Date of Injury: 12/18/2008

Time: 14:30

MISCELLANEOUS, NOC

UNKNOWN/ NOT

Date Reported: 12/18/2008

Nature of Injury: UNKNOWN/NOT REPORTED

REPORTED

Cause of Injury: MISC. CAUSES-OTHER

Address Where Injury Occurred:

2420 GULFWAY DR

PORT ARTHUR TX 77640-4541

County: JEFFERSON

Witnesses:

Name:

Phone:

Name:

Phone:

Name:

Phone:

How and Why the Injury/Iliness Occurred

Yes

FATALITY. EE WAS CLIMBING ON A TRUCK TO HELP IN THE CHEMICAL VENTING PROCESS. EE STARTED BLEEDING FROM HIS NOSE AND FAINTED. EE PASSED DUE TO ANEURYSM.

| A MM DD NH715 TX 12 18 FDID * State * Incident Date * | YYYY Delete NFTRS -1 2008 08-0012882 000 Change Basic Station Incident Number + Exposure + No Activity No Activity |
|--|---|
| | adicate that the address for this incident is provided on the Wildland Fire "Alternative Location Specification". Use only for Wildland fires. |
| X Street address Intersection In front of Rear of Adjacent to Directions | ORT ARTHUR TX 77640 - |
| C Incident Type * | E1 Date & Times Midnight is 0000 E2 Shift & Alarms |
| 321 EMS call, excluding vehicle | Check boxes if Month Day Year Hr Min Sec Local Option dates are the |
| D Aid Given or Received* | same as Alarm ALARM always required Date. Alarm * 12 18 2008 14:10:33 Shift or Alarms District Platoon |
| 1 Mutual aid received | ARRIVAL required, unless canceled or did not arrive |
| 2 Automatic aid recv. 3 Mutual aid given 4 Automatic aid given 5 Other aid given N X None Their FDID Their State Their FDID Their State | X Arrival * 12 18 2008 14:19:20 E3 CONTROLLED Optional, Except for wildland fires Special Studies Local Option LAST UNIT CLEARED, required except for wildland fires Last Unit Cleared 12 18 2008 16:45:03 Special Study Value |
| F Actions Taken * | G1 Resources * G2 Estimated Dollar Losses & Values |
| 23 Extricate, disentangle Primary Action Taken (1) | Check this box and skip this section if an Apparatus or Personnel form is used. Apparatus Personnel Suppression 0002 0006 Contents \$, 000, 000 EMS 0001 PRE-INCIDENT VALUE: Optional |
| Additional Action Taken (2) | Other |
| Additional Action Taken (3) | Check box if resource counts |
| | include aid received resources. Contents \$, 000 , 000 |
| Completed Modules Fire-2 | uries N None Not Mixed Assembly use 1 Natural Gas: slow leak, no evaluation or HazMat actions 2 Propane gas: <21 lb. tank (as in home BBQ grill) 3 Gasoline: vehicle fuel tank or portable container 4 Kerosene: fuel burning equipment or portable storage 5 Diesel fuel/fuel oil:vehicle fuel tank or portable 6 Household solvents: home/office spill, cleanup only 7 Motor oil: from engine or portable container 8 Paint: from paint cans totaling o Other: Special HazMat actions required or spill > 55gal., flease complete the HazMat form Other mixed use NN Not Mixed Assembly use Education use Residential use Residential use 51 Row of stores 52 Enclosed mall 58 Bus. & Residential Office use Industrial use 63 Military use Farm use Other mixed use |
| J Property Use* Structures | 341 Clinic, clinic type infirmary 539 Household goods, sales, repairs 342 Doctor/dentist office 579 Motor vehicle/boat sales/repair |
| 131 Church, place of worship 161 Restaurant or cafeteria 162 Bar/Tavern or nightclub 213 Elementary school or kindergarten 215 High school or junior high 241 College, adult education 311 Care facility for the aged 331 Hospital Outside | 361 Prison or jail, not juvenile 571 Gas or service station 419 1-or 2-family dwelling 599 Business office 429 Multi-family dwelling 615 Electric generating plant 439 Rooming/boarding house 629 Laboratory/science lab 449 Commercial hotel or motel 700 Manufacturing plant 459 Residential, board and care 819 Livestock/poultry storage(barn) 464 Dormitory/barracks 882 Non-residential parking garage 519 Food and beverage sales 891 Warehouse |
| 124 Playground or park 655 Crops or orchard 669 Forest (timberland) 807 Outdoor storage area 919 Dump or sanitary landfill | 938 Graded/care for plot of land 984 Industrial plant yard 946 Lake, river, stream 951 Railroad right of way Lookup and enter a Property Use code only if you have NOT checked a Property Use box: 960 Other street Property Use 891 |
| 931 Open land or field | 962 Residential street/driveway Warehouse NFIRS-1 Revision 03/11/99 |

| K1 Ferson/Entity Involved Local Option | ECA Environmental Services 409 - 293 - 6854 Business name (if applicable) Area Code Phone Number |
|--|---|
| Check This Box if same address as incident location. Then skip the three duplicate address lines. Check This Box if Mr., Ms., Mrs. First (b) (4) Number | |
| State zip Code More people involved? Check th | is box and attach Supplemental Forms (NFIRS-1S) as necessary |
| K2 Owner Same as person involved? Then check this box and skip The rest of this section. | Business name (if Applicable) Area Code Phone Number |
| Check this box if same address as incident location. Then skip the three duplicate address lines. Mr.,Ms., Mrs. First Mrs. Mrs. First Mrs. Mrs. Mrs. First Mrs. Mrs. Mrs. First Mrs. Mrs. Mrs. First Mrs. Mrs. Mrs. First Mrs. Mrs. Mrs. First Mrs. Mrs. Mrs. Mrs. Mrs. Mrs. Mrs. Mrs. | Name MI Last Name Suffix Prefix Street or Highway Street Type Suffix Apt./Suite/Room City |
| FULL ARREST/E2 EMS ADVISED; RETONE; 14:20:17 00005062: TALON'S/ENVIRONMENTAL//RD BE: e2-heavy set man ontop of 14:33:23 00005145: hrl has ////st mary; 14:45:56 00005 e2 at st mary; 15:03:45 000 this as a hazmat incident; 15:31:04 00005145: hrl tone 16:04:51 00005145: msds is | W2 REQUEST R1 ASSIST; 14:21:44 00005062: TURN AT FORE IC BRIDGE ST COM ON RIGHT DOWN DIRT RD; 14:28:08 00005145 the tanker; 14:30:06 00005145: bringing him down now; a firefighter riding with ems to hospital enroute to pick him up 145: e2 to st marys to give information; 14:56:51 00005145: 05145: told unit 3 to call the chief the hospital is treating 15:19:40 00005145: e2 leaving st mary going back to scene; d out of service; 15:32:18 00005145: e2 back on the csene; non toxic; 16:07:20 00005145: e2 back in service going to : ernout to st mary hospital; 16:23:31 00005145: at st mary |
| | ispatched To 2420 S Gulfway DR /PORT ARTHUR, TX 77640. The he incident was determined to be a(n) EMS call, excluding |
| 14:19:20 arrived on scene. The following actions were perfect that it is a second to the second to t | |
| Units responding were: Unit E2 responded. | |
| L Authorization | |
| 29450 PEAN Officer in charge ID Signature | Position or rank Assignment Month Pay Year |
| Check Box if X 29450 same as Officer Member making report ID in charge. PEAK Signatu | Rosition or rank Assignment Month Day Year |

Narrative:

On 12/18/2008 at 14:10:33 dispatched To 2420 S Gulfway DR /PORT ARTHUR, TX 77640. The location is a Warehouse. The incident was determined to be a(n) EMS call, excluding vehicle accident with injury.

14:19:20 arrived on scene.

The following actions were performed on scene:

Extricate, disentangle

Provide advanced life support (ALS)

Units responding were:

Unit E2 responded.

Unit HR1 responded.

Unit SC63 responded.

16:45:03 all units back in service.

Dispatched to difficulty breathing. While enroute the call was upgraded to a full arrest. AOSTF patient on top of a tanker. Company emloyees had begun cpr. Fire engineer Barideaux and fire fighter Delacerda climbed on top of tanker and took over cpr. Captain Peake directed resources needed for the retrieval of patient from atop the tanker. Company employee made mention that the patient may have been exposed to toxic fumes. FD backboarded the patient and lowered the patient to the ground and onto waiting Stat Care ems stretcher. Fire fighter Thibedeaux rode with patient to SMH to assist ems.

HR1 went to SMH while E2 gathered patient info. E2 went to SMH and found hospital doing a hazmat wash on patient. E2 returned to scene to take drager readings from top of tanker. Drager read 1 ppm of H2S. Obtained msds sheet on tanker contents. Msds showed chemical to be sulfurized isobutylene. Toxicological Data showed all areas to be: Practically non-toxic. E2 returned to SMH msds sheet for distribution to the hospital and JP. E2 returned to service.

HR-1 Supplement:

HR-1 responded to assist. FF Thibodeaux rode in with EMS to St. Mary. Upon arrival the EMS staff complained of a strong odor from the pt. and his clothing. Hospital staff removed clothing and placed into a biohazard bag. FD placed a meter in the bag. The meter detected no lel, no H2S, no CO, and indicated an O2 % of 20.9. The deceased was placed in a secure room ouitside of the ER. FF Thibodeaux was provided with scrubs from the hospital and was

Port Arthur F.D. NH715 12/18/2008 08-0012882

| NH715 | TX | ММ 12 | DD 18 | YYYY 2008 | [2] | 08-0012882 | 000 | Complete Narrative |
|--------|---------|-------------------|------------|-------------------------------------|---------|-----------------|------------|-----------------------|
| FDID * | State 🛊 | Incident 1 | Date * | ··································· | Station | Incident Number | Exposure # | Narrative |

| | | | | | _ | |
|----|----|----|-----|---|---|---|
| Na | TT | aı | - 7 | v | ρ | • |

able to remove her clothing and shower. Capt. Achord and FE Richard donned class B suits and airpacks and assisted in placing the deceased into two body bags for transfer to the morgue. Both the class B suits and the pt.'s clothing went with the decedant to the morgue.

Port Arthur F.D. NH715 12/18/2008 08-0012882

| A. NH715 * | MM DD YYYY TX 12 18 2008 State * Incident Date * | 2 Station | | -0012882 | 2 000 Exposure | l Delete i | FIRS - 10 Personnel | |
|-------------------------|---|-------------------------------|-------------|-------------|---|-----------------|--|--|
| B Apparatus or Resource | Check if same as alarm date | Hours/mins | x | | Number Of * Check ONE box for each apparatus to indicate its main use at the incident. | | Actions Taken List up to 4 actions for each apparatus and each personnel. | |
| 1 ID E2 | Dispatch X 12 18 2006 Arrival X 12 18 2006 Clear X 12 18 2006 | 3 14:19 | Sent X | 3 | X Suppression EMS Other | | | |
| Personnel ID | Name | Rank or Grade | Attend | Action Take | i l | Action Taken | Action Taken | |
| 29450 49817 70785 | PEAKE, THOMAS DELACERDA, TRAVIS BARIDEAUX, THADDEUS | CA FF FF | x x x | | | | | |
| 2 ID HR1 | Dispatch X 12 18 2008 Arrival X 12 18 2008 Clear X 12 18 2008 | 3 14:30 | Sent X | 3 | X Suppression EMS Other | <u> </u> | | |
| Personnel ID | Name | Rank or Grade | Attend | Action Take | | Action Taken | Action Taken | |
| 25700 30005 30725 | ACHORD, JON RICHARD, BRANDAN THIBODEAUX, ANGELL | CA FE FF | x x x | | | | | |
| 3 ID SC63 | Arrival X 12 18 2008 | 3 14:10 3 14:22 3 16:45 | Sent X | <u> 0</u> | Suppression EMS Other | | | |
| Personnel ID | Name | Rank or Grade | Attend X | Action Take | | Action Taken | Action Taken | |
| | | | | | | | | |

****** -IND. XMT Journal- ********* Date DEC-22-2008 **** Time 13:36 ******

Date/Time = DEC-22-2008 13:34

Journal No. = 183

Comm. Result = OK

Page(s)

= 004

Duration

= 00:00:53

File No.

= 286

Mode

= Memory Transmission

Destination = 2812866352

Received ID = /

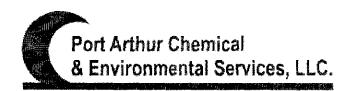
Resolution = Fine

-CES ENVIROMENTAL -

***** DP-C264 ********************

_ ***** _

7137488664- *******



2420 S. Gulfway Dr. Port Arthur, TX 77641 Phone: (630) 212-0437 Fax: (713) 676-1676

Fax

то: Texas Mutual From: Karl Guidry

713-676-1460

Fax: 512-224-3889 Pages:44

Pages:44Pages to follow

Attn: Karen Crouse Date: January 12, 2009

See attached requested documentation regarding our employee Joey Sutter

Karl Guidry CES Environmental Services, Inc. HSE Manager 4904 Griggs Rd Houston, Texas 777021

713-676-1460 713-676-1676 Fax kguidry@cesenvironmental.com



Patriot Security EOC Proudest Employee Owned Company In TEXAS:

INCIDENT REPORT

| DATE: | TIME: ZYZAM Z'O V PM |
|---|--|
| 12-15-08 POST: Ex. Beaumont Enterprise | LOCATION: Ex. 2 nd Floor |
| SECURITY OFFICERS NAME (PRINT): | POLICE DEPARTMENT: Ex. Beaumont PD |
| HAWREL L. HICKINSON | AMBULANCE: Ex. Priority One |
| | STAT CANE |
| WITNESS: | FIRE DEPARTMENT: Ex. Beaumont FD FORT BRITANT |

PRINT INCIDENT DETAILS IN ALL CAPITAL LETTERS
COMPLETE INCIDENT DRAWING ON BACK

| BY APPROL 3:03 I WEARD A CALL FOR PLEEP. PERSON CHUNG FOR HOLP WAS SUZI MOCK CES EMPLOYEE DENTOP |
|--|
| |
| |
| OF TRAILER TANK 267 WITH JORY SUTTEN CAS EMPLOYER |
| JOBY SUTTEN WAS 13855ED-OUT ONTOP OF TOUR |
| T RAN TO TANK FROM SCALE BUILDING CALLING ON |
| KADIO FOR MELO- BRAD WOOD CES ENDLOYER BUSEASES |
| ANSWERD CALL FOR HELP BURIUNG HT SITH WITH-IN |
| A MIN. OFFICE MONAGAN K. PEESE COLLED 911 DE |
| At APPRX - 2:04 PM. At BREROY: 2:20 PART |
| MATHUR 1/0 BRAINED. S/S JONES ON SITE TO |
| 195515J. CHILL OFFICE TO REPORT. PROBLEW. HI BPPROV |
| D' BU STAT CARE GUBBOGAUCE ARRIVED ON SUTE |
| PORT ANDIUR F/D AND CES EMPLOYERS HELP BRING |
| JOHN SUTTEN OFF 1-P OF TANK 2:38 STAT CARE |
| AMBULANCE WITH SITE WITH JOEY SUTTEN ON BORRD |
| PRANT MANACON KAL ANDERSON O OPENATION SUPER DISOR |
| BRINE WENTERING WOLLED BY APPROX 9:15 BS THEY PETERLED |
| FROM LURCH |

Security Officer's Signature: Henry Employee # 1006

Confidential and Proprietary Patriot Security EOC

Proudest Employee Owned Company in TEXAS!

OSHA- Document Request SUBPOENA #1
COMPANY: Port Arthur Chemical and Environmental Services

INSPECTION #: 311960975

REQUESTED DATE: 20 January 2009

ATTACHMENT A

| Item | Description | Date received | |
|------|---|---------------|-------------------------------------|
| 1 | Injury & Illness logs (OSHA 300& 300A) for the past 3 years | SUBMITTED | |
| | Bill of ladings for the last 11 loads received prior to the 18 December | SENT | |
| 2 | 2008 incident | | |
| 3 | Document showing all employees | SENT | |
| 4 | MSDS for any and all process chemicals at the Port Arthur Chemical and Environmental Services facility | SEN | > VERIFY |
| 5 | Copy of placard on the truck involved with the 18 December 2008 incident | SEN! | |
| 6 | Document showing the witnesses of the 18 December 2008 incident | SUZI MOUL | - STATEMENT |
| 7 | Copy of the coroners report | NOT PRIVY - | |
| 8 | Written procedures for sampling the trailers as it existed at the time of the incident on 18 December 2008 | SENT 07/19 | |
| 9 | PPE (personal protective equipment) assessment & certification | | * GUINI |
| | PPE requirements for taking samples of the trailers as it existed at the | Speded out | • |
| 10 | time of the incident on 18 December 2008 | W 83 P | WP2 () |
| 11 | Written Respiratory Protection Program | - | KPZINT |
| 12 | Hydrogen sulfide program/practices | - | * PRINT |
| 13 | Written disciplinary program/ policy | | & PRINT |
| 14 | All near misses and incident reports for 2008 | - | - BRIVEN |
| 15 | Specific sampling procedures for extracting samples from trailers as it existed at the time of the incident on 18 December 2008 | (8) | |
| 16 | The 18 December 2008 sample analysis of the contents of the trailer (#267) | | -1C.A. |
| 17 | Written process overview explaining the processes at the Port Arthur Chemical & Environmental Services site | | |
| 18 | Process flow diagram for the processes at the Port Arthur Chemical & Environmental Services site | _ | Lhainn |
| 19 | P&Ids (piping and instrumentation drawings) for the processes at the Port Arthur Chemical & Environmental Services site | | ARIAN |
| 20 | Any and all batch records for the processes from 16 December 2008 to 19 December 2008 | | -BRIAN -BRIAN -BRIAN BRIAN |
| 21 | Any and all pH readings for the processes from 16 December 2008 to 19 December 2008 | _ | spiarl |

PACES Census

| Employee | Phone |
|-----------------------|---------|
| Andersen, Keld | (b) (4) |
| Brannon, Rickey H | |
| Crawley, Kevin D | |
| Cumberland, Jimmy D | |
| Mendoza, Juan | |
| Mock, Suzi A | |
| Reese, Krissy H | |
| Rudd, Michael C | |
| Saylor, Christopher R | |
| Shaddix, Dennis M | |
| Sittig, Charles B | |
| Sutter, Joey | |
| Weathers, Brian D | |
| Wilson, Kevin L | |
| Wood, William B | |

manner this e-mail or any attachments to it. If you have received this message in error, please notify the sender by replying to this message and delete it from your computer.

Karl Guidry

From: Scarpa, Kimi - OSHA [Scarpa.Kimi@dol.gov]

Sent: Tuesday, December 23, 2008 4:43 PM

To: Karl Guidry

Cc: Figueroa, Joann - OSHA; Hurlburt, Tanya - OSHA

Subject: OSHA document request for CES

Attached is the document request for both sites. If you have any question, contact me. Thank you.

Kimi

17625 El Camino Real, Suite 400 Houston, TX 77058 281-286-0583

Fax: 281-286-6352

OSHA's Mission: To assure safe and healthful working conditions for working men and women.

HSAO's VISION: Utilizing the talents and skills of OSHA's finest, we will execute "The Missions" professionally, effectively, efficiently and with respect toward one another and our constituents. To meet this vision we will use the values set forth in TEAM CORE.

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OSHA- Document Request SUBPOENA #1
COMPANY: CES Environmental
INSPECTION #: 311960942

REQUESTED DATE: 20 January 2009

ATTACHMENT A

| Item | Description | |
|------|---|------------------|
| H1 | Injury & Illness logs (OSHA 300& 300A) for the past 3 years | |
| H2 | Incident report for the rupture on 6 December 2008 | |
| Н3 | Piping and instrumentation drawings (P&ID) for the oxidizer | |
| H4 | Chemical stream component information | |
| | Procedure(s) used for the activities on 16 December 2008 in and around | |
| H5 | the oxidizer unit. | |
| | Detailed piping and instrumentation drawings for the "oil recycling unit" | |
| H6 | including all emission controls | TANK FARM |
| | Document(s) showing all employees and their job titles and area they | |
| H7 | work | |
| | PPE (personal protective equipment) assessment for the Houston CES | L. Come D |
| H8 | Environmental site — 6 | rm4 4 SELED |
| H9 | Written Respiratory Protection Program | DPAS TONG MANUAL |
| | Written process overview explaining the processes at the Houston CES | - and manual |
| H10 | Environmental site | Drivs 1947 |

OSHA- DOCUMENT REQUEST #1 COMPANY: Goodyear Tire & Rubber Houston Chemical Plant INSPECTION #: 311957161 REQUESTED DATE: 17 June 2008

ATTACHMENT A

| Item | Description | Date received |
|------|---|------------------|
| 1 | Injury & Illness logs (OSHA 300& 300A) for the past 3 years | 17 Dec 08 |
| 2 | Incident report for the rupture on 6 December 2008 | 17 Dec 08 |
| 3 | Piping and instrumentation drawings (P&ID) for the oxidizer | 17 Dec 08 |
| 4 | Chemical stream component information | 17 Dec 08 |
| 5 | Procedure(s) used for the activities on 16 December 2008 in and around the oxidizer unit. | 9/14/09 |
| 6 | Detailed piping and instrumentation drawings for the "oil recycling unit" including all emission controls | SENT- |
| 7 | Listing of all employees and their job titles and area they work | SENT |
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12/19/2008

C E S ENVIRONMENTAL SERVICES I 4904 GRIGGS RD HOUSTON TX 77021-3208 mmoser@cesenvironmental.com

Notification Confirming Receipt of Claim

Date of Injury:

12/18/2008

Injured Worker:

SUTTER, JOEY

Claim Number: Policy Number:

0001086044

Attached is a copy of the information you reported to Texas Mutual Insurance Company which was used to establish this claim. You may submit additional claim information to Texas Mutual Insurance Company. If you have questions regarding this report of injury please contact us at (800) 859-5995.

If your policy includes our workers' compensation health care network option you are required by law to obtain a second Employee Acknowledgement of Workers' Compensation Network Form signed by the injured worker. Please submit a copy of the signed, second acknowledgement form to Texas Mutual Insurance Company. You can find a copy of the form online at www.texasmutual.com/hcn/hcn.shtm

Below please find information that will help you through the claim process:

To submit additional claim information:

To locate a treating doctor:

Mail to: P. O. Box 12029

Austin, Texas 78711-2029

www.texasmutual.com/workers/iwADL.shtm

Fax to: (512) 224-3889

To contact the handling adjuster:

Call: (800) 859-5995

Monday - Friday; 8:00 a.m. - 5:30 p.m.

To obtain a copy of the Employer and Employee Rights and Responsibilities in the

Workers' Compensation System:

www.texasmutual.com/employers/erRights.shtm

To locate a pharmacy, or for pharmacy questions, contact Scripnet:

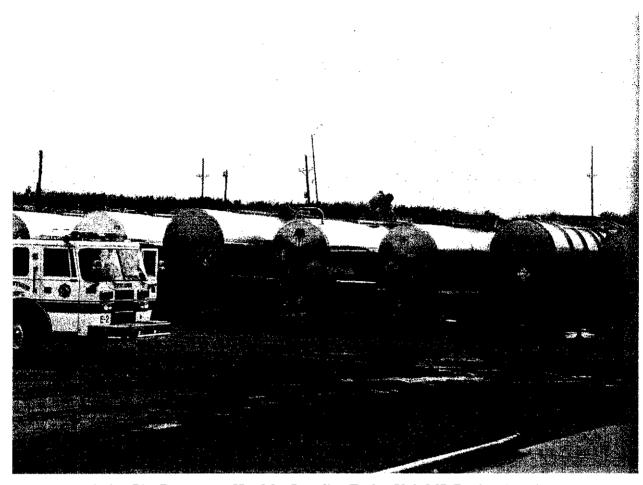
Call: (888) 880-8562 www.scripnet.com

To obtain a copy of the Employer and Employee Rights and Responsibilities for the workers' comp health care network:

www.texasmutual.com/hcn/hcn.shtm

Additional Texas Mutual® online services at www.texasmutual.com, available 6 a.m. - 9 p.m., include:

- o Obtain logon id, or for immediate logon id, call (800) 859-5995, M-F, 8:00 a.m. 5:30 p.m.
- Submit first report of injury in the Employers section
- Submit wage statement when reviewing loss runs and claim details
- Obtain specific claim summary information



Port Arthur Fire Department Haz-Mat Sampling Tanker Unit 267 (Farther Away)

See Port Arthur Fire Department Incident Report # 08-0012882 Page 3 HR-1 Supplement
Indicating Draeger Read of 1 ppm of H2S (Incident Report Attached)



Port Arthur Fire Department Haz-Mat Sampling Tanker Unit 267 (Close-up)

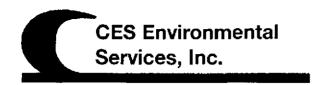
See Port Arthur Fire Department Incident Report # 08-0012882 Page 3 HR-1 Supplement
Indicating Draeger Read of 1 ppm of H2S (Incident Report Attached)

OSHA- DOCUMENT REQUEST #1 COMPANY: Goodyear Tire & Rubber Houston Chemical Plant INSPECTION #: 311957161

REQUESTED DATE: 17 June 2008

ATTACHMENT A

| Item | Description | Date received |
|------|---|---------------|
| 1 | Injury & Illness logs (OSHA 300& 300A) for the past 3 years | 22 Dec 08 |
| 2 | Bill of ladings for the last 11 loads of SIB received | 19 Dec 08 |
| 3 | List of all employees | 23 Dec 08 |
| 4 | MSDS for sulfurized isobutylene | 19 Dec 08 |
| | Copy of placard on the truck involved with the 18 December 2008 | |
| 5 | incident | 19 Dec 08 |
| 6 | List of witnesses of the 18 December 2008 incident | |
| 7 | Copy of the coroners report | |



4904 Griggs Road Houston, TX 77021 Phone: (713) 676-1460 Fax: (713) 676-1676

Fax

To: USDOL OSHA

From: K

Karl Guidry

Fax:

281-286-6352

Pages: / # Pages to follow

KAG

Attn:

Kimi Scarpa

Date:

January 14, 2009

See attached requested documentation.

Karl Guidry CES Environmental Services, Inc. HSE Manager 4904 Griggs Rd Houston, Texas 777021

713-676-1460 Ext 115 713-676-1676 Fax kguidry@cesenvironmental.com ******* -IND. XMT Journal- ********* Date JAN-14-2009 **** Time 14:03 ******

Date/Time = JAN-14-2009 14:02

Journal No. = 016

Comm. Result = OK

Page(s) = 002

Duration

= 00:00:25

File No.

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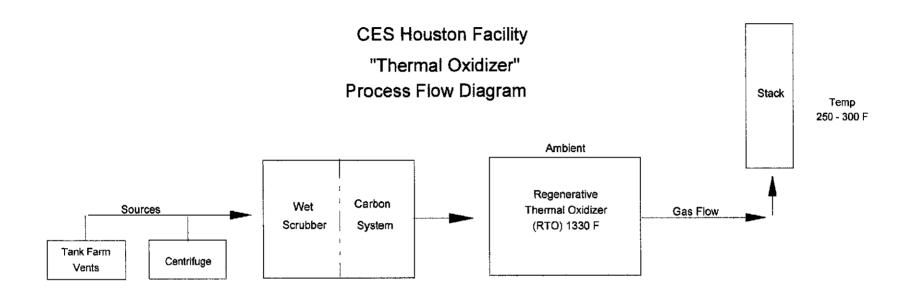
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Resolution = Fine

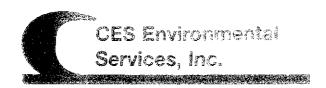
-CES ENVIROMENTAL -

_ ***** _

7137488664- *******



| 4904 G | mental Services, Inc. Friggs Road on, TX 77021 676-1460 | | | | |
|-------------------------|--|--|--|--|--|
| _ | ouston Facility mal Oxidizer" | | | | |
| Drawn By: | CGH/cm | | | | |
| Date: November 11, 2008 | | | | | |
| | | | | | |



4904 Griggs Road Houston, TX 77021 Phone: (713) 676-1460

Fax: (71.

(713) 676-1676

Fax

To: USDOL OSHA From: Karl Guidry
(b) (4)

Fax: 281-286-6352

Pages: ਿਸ਼ੀ Pages to follow

KAG

Aun: Kimi Scarpa

Date

January 14, 2009

See attached requested documentation.

Karl Guidry CES Environmental Services, Inc. HSE Manager 4904 Griggs Rd Houston, Texas 777021

713-676-1460 Ext 115 713-676-1676 Fax kquidry@cesenvironmental.com ******* -IND. XMT Journal- ******** Date JAN-14-2009 **** Time 14:52 *******

Date/Time = JAN-14-2009 14:50

Journal No. = 019

Comm. Result = OK

Page(s) = 006

Duration

= 00:01:03

File No.

= 522

Mode

= Memory Transmission

Destination = 2812866352

Received ID = /

Resolution = Fine

-CES ENVIROMENTAL -

- **** - 7137488664- *******

CES Environmental RTO Work Plan

On 12-6-08 at ~ 12:45 pm, the CES Environmental Services, Inc. facility, located at 4904 Griggs Rd experienced a pressure release associated with the thermal oxidizer. This unit burns/oxidizes organics in the air streams vacuumed off the hydrocarbon storage tanks and processing operations. It appears the Thermal Oxidizer unit overheated, resulting a programmed safety system shutdown of the unit. After a period of cool down phase, the unit restart permissive was released in the logic. The CES Environmental Services, Inc Processing Director was in the process of restarting the unit when the pressure release happened. The pipe rupture was accompanied by a loud noise and vibration.

Preliminary investigation led facility personnel to believe that the air mixture going into the Thermal Oxidizer unit may have been oversaturated after the unit cool down phase. It appears the saturated air entered the Thermal Oxidizer chamber and appears to have flashed causing a rapid expansion of air that ruptured the vent piping.

CES Environmental Services, Inc hired Donald L. Corwin PE of Therma-A-Cor Consulting, Inc whose address is 418 Rawlings Rd., Phoenixville, PA 19460 to perform a "root cause analysis" to determine the probable cause of the incident and to make recommendations to prevent future occurrences of such an event the subject of this report. Below are the work procedures which were in place on December 16, 2008.

Piping Design

The piping of the fume collection and the tank collection system are designed to carry a very dilute and a highly variable organic vent stream from the centrifuge and tank areas. The two lines are installed to allow the tank vent line to terminate operation during periods of high organic concentration. The centrifuge line is a high flow line utilized for odor control. This line will not have high organic concentrations.

The tank vent line is a sweep through line that has the potential of high organic concentrations. These organic materials cannot be fully defined. They are the result of the wide variety of materials processed by the facility. The line is segregated from the dilute centrifuge line to provide additional control on the feeding of this line into the RTO.

Centrifuge Fume Line

Therm-A-Cor Consulting

Page 1 of 5

CES Environmental RTO Work Plan

- 1. The centrifuge pipe is designed on a diameter that will span the largest distance between the current supports. A minimum of 24 inches would be required for a 3000 CFM draw rate from the centrifuge room.
- 2. A 24 inch diameter light wall duct is needed to have a low pressure drop 0.5 inwc per 100 effective feet at a flow rate of 3000 CFM. If the flow rate needed by the centrifuge room is less than 3000 CFM.
- 3. The current shut off valve mounted on top of the ID fan is to be reused.
- 4. Pressure indicators will be located at the start and end of the fume line. Operational personnel will monitor these indicators on a daily basis. These gauges will be ranged on the order of 0 to 15 inwc (negative).
- 5. The centrifuge piping should be sloped downward to collect condensed steam and liquids. A collection barrel may be located in the containment area adjacent to the RTO

Scrubber Line

- 6. The scrubber line is a separate line that enters in the fume manifold immediately upstream of the ID blower.
- 7. A flame arrester is to be installed as close as possible to the main air manifold. The flame arresters will be mounted in vertical piping to prevent liquid from collecting in the unit.
- 8. The line size of the scrubber line is 6 inches. The maximum fill rate of the tanks with the pumps available is on the order of 600 gpm (2 at 300 gpm).
- 9. The shut off valve on the scrubber vent line to the RTO is bubble tight shut off. This valve will close when the temperature of the oxidizer is greater than 150 Deg F (actual value to be documented at RTO start up) above the set point temperature. An alarm will sound to alert the operators of the high organic loading condition.
- 10. The plant has determined that the scrubber is to be bypassed when the RTO is operating. The control system will be modified to automatically start the scrubber when the
- 11.Pressure indicators are installed to allow for continuous monitoring of the system. The range of the pressure gauges is 0 to 15 inwc (negative).
- 12. The scrubber will be removed from the area while repairs are accomplished on the RTO. The scrubber will be taken to the MRI shop for repairs.
- 13. A blind flange will be installed on the piping from the tanks to the scrubber to prevent fumes from entering the RTO fume line until the safe RTO operation has been verified.

Therm-A-Cor Consulting

CES Environmental RTO Work Plan

| 14. The tank conservation vents will be | e utilized to protect the tanks from over and |
|---|---|
| under pressure during this period. | When the RTO is functional, the fumes from |
| the tanks will be drawn into the RT | TO. |

PLC Review

- A. The PLC control will be printed, verified and reviewed with plant personnel. A summary will be provided for plant personnel for ready reference. Items on the review are:
 - a. The hard wired ladder logic will be reviewed to verify that the system will provide the required safety. A review document will be generated.
 - b. The scrubber vent line will have an RTO shut down temperature designated as the high temperature. The scrubber line will be closed. An alarm and light will flash indicating the flow from this line is terminated.
 - c. The total RTO shut down temperature is designated as the high high temperature. This high high temperature will shut down the RTO and close the centrifuge vent line. An alarm will sound and a light will flash.
 - d. The fresh air valve opens as the temperature exceeds a set point that is below the high temperature shut off of the scrubber fume line. This will allow additional air into the system to dilute the high organics from the scrubber line.
 - e. The scrubber line flow will be terminated prior to the maximum temperature. The scrubber will vent to atmosphere.
- B. The hard wired safety system is to be reviewed, documented and tested.
- C. The restart of the scrubber line will be by supervisory personnel after any termination by a safety switch.
- D. The scrubber line vents to atmosphere when not to the RTO after management authorization.
- E. An operational manual will be generated to describe the actions of the unit and the typical responses needed by the operational and management personnel to each of the alarm conditions. Normal conditions will be defined

Steps to Restart RTO

1. System Documentation

The current PLC logic documentation
Narrative of the control logic generated
All safeties will be documented
Hard wired logic will be documented
PHA (Process Hazards Analysis)
Operators to be trained on the RTO changes.

2. RTO operational evaluation at start up

All safeties to be tested
All control parameters to be tested
Management part of all restarts after safety shutdown
Verification of all grounding connections in ductwork and RTO

3. Wet Scrubber

Remove and repair unit
Verify operation and rating of all conservation vents on tanks
Verification of all motor and blower ratings
Install unit verifying all grounding requirements
Operators to be trained on the wet scrubber

4. Evaluation of particulates obtained in RTO

Karl Guidry

From:

Scarpa, Kimi - OSHA [Scarpa.Kimi@dol.gov]

Sent:

Thursday, January 08, 2009 4:28 PM

To:

Anissa Wright

Cc:

Karl Guidry

Subject: RE: OSHA document request for CES

This is to confirm that the email was received.

Kimi Ocarpa

17625 Et Camino Real, Quite 400

Houston, TH 77058

281-286-0583

Fax: 281-286-6352

OSHA's Mission: To assure safe and healthful working conditions for working men and women. HSAO's VISION: Utilizing the talents and skills of OSHA's finest, we will execute "The Missions" professionally, effectively, efficiently and with respect toward one another and our constituents. To meet this vision we will use the values set forth in TEAM CORE.

From: Anissa Wright [mailto:awright@cesenvironmental.com]

Sent: Thursday, January 08, 2009 12:05 PM

To: Scarpa, Kimi - OSHA

Subject: RE: OSHA document request for CES

Good morning Ms. Scarpa,

Attached you will find the Census for both Port Arthur Chemical and Environmental Services and CES Environmental Services. Please contact me with any questions.

Thanks

Anissa

From: Karl Guidry

Sent: Thursday, January 08, 2009 10:36 AM

To: Anissa Wright

Subject: FW: OSHA document request for CES

If you have completed the census requested by OSHA indicating employees and job titles, please send it to Scarpa.Kimi@dol.gov.

Thanks,

Kari

From: Karl Guidry

Sent: Monday, January 05, 2009 9:24 AM

To: 'Scarpa, Kimi - OSHA'

Subject: OSHA document request for CES

Good morning Kimi,

You phones are still indicating busy. Please call me at 832-287-0862 regarding delivery of the documents

requested.

Karl Guidry

From: Karl Guidry

Sent: Sunday, January 04, 2009 10:45 AM

To: 'Scarpa, Kimi - OSHA'

Subject: RE: OSHA document request for CES

Good morning Kimi,

Please call me when you get this message. Your number has been busy since we spoke earlier.

Karl Guidry

From: Scarpa, Kimi - OSHA [mailto:Scarpa.Kimi@dol.gov]

Sent: Tuesday, December 23, 2008 4:43 PM

To: Karl Guidry

Cc: Figueroa, Joann - OSHA; Hurlburt, Tanya - OSHA

Subject: OSHA document request for CES

Attached is the document request for both sites. If you have any question, contact me. Thank you.

Kimi

17625 El Camino Real, Suite 400 Houston, TX 77058 281-286-0583

Fax: 281-286-6352

OSHA's Mission: To assure safe and healthful working conditions for working men and women.

HSAO's VISION: Utilizing the talents and skills of OSHA's finest, we will execute "The Missions" professionally, effectively, efficiently and with respect toward one another and our constituents. To meet this vision we will use the values set forth in TEAM CORE.

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This e-mail message and any attachments to it may contain confidential information. The information contained in this transmission is intended solely for the use of the individual(s) or entities to which the e-mail is addressed. If you are not the intended recipient, or an employee or agent responsible for delivering this message to the intended recipient, you are hereby notified that you are prohibited from reviewing, retransmitting, converting to hard copy, copying, disseminating, or otherwise using in any



Claim & Information Services P.O. Box 12029 Austin, TX 78711-2029 1-800-859-5995 (512) 224-3800 (512) 224-3889

January 29, 2009

C E S ENVIRONMENTAL SERVI ATTN: KARL GUIDRY 4904 GRIGGS RD HOUSTON, TX 77021-3208

Re:

Claim #:

9930000556027

Employee:

JOEY SUTTER

Soc. Sec.:

401-08-2362

Employer:

C E S ENVIRONMENTAL SERVI

Date of Injury: 12/18/2008 DWC#:

09169549

Dear Karl,

Thank you for submitting the attached Wage Statement. We have reviewed the form and have found information that must be changed to meet the requirements of the Division of Workers' Compensation. Please make the following corrections:

- 1) Period No. 13 includes the date of injury; please provide wages by adjusting the reporting period backward so the date of injury is not included,
- 2) Period No. 7 reports only 39.13 hours worked. Why the decrease in hours for this week?
- 3) The no. of hours worked appear to reflect more than 40 hours a week except of period no. 7. Hours worked over 40 hours are they overtime hours?
- 4) Under Non-Pecuinary wage information, you report that pay period no. 12 and no. 13 employer paid health insurance. Did he not have this benefit prior to that time?
- 5) Under Non-Pecuinary wage information, the employer provided clothing/uniforms but no specific value was given. Please provide a specific value for this benefits for each reported period this benefit was provided prior to the injury of 12/18/08.

Please note that the salary history cannot include, nor go beyond, the date of injury. Thank you for your prompt attention to this matter. If you have any questions, please call me at 1-800-859-5995 ext. 7291.

Sincerely,

Karin T. Crouse

CAT WORKERS' COMP SPEC II.

Enclosure: Wage Statement

| Post-it® Fax Note 7671 | Date /. 3D. 29 pages ► 3 |
|------------------------|--------------------------|
| TO KARL G | From KARIA |
| Co./Dept. CES | CO. TMIC |
| Phone # | Phone # ext. 1291 |
| Fax = 713 748 8664 | Fax # |

| Send to workers' compensation carrier: | | 73021 | IM# | 551027 | |
|--|--|--|--|--|--|
| | | | | | |
| The Texas Workers' Compensation Act and require an employer to provide an Employer's vicompensation Insurance carrier (carrier) and impresentative, if any. The purpose of the form wage information to the carrier for calculating in Wage (AWW) to establish benefits due to the employer (AWW) to bested on the wages the employer of the employer did not work the full 13-a all forms of remuneration payable to an omincluding frings benefits. To simplify fling, at monthly, biweekly, or weakly manner as discussioned. All controls of the employer who falls without good covers establishment as required by the Texas Work Labor Code, Section 408,063(c) and Worker's (controls and controls and administrative penalty. | Workers' Compensation rules Vage Statement to its workers' the claimant or the claimant's in a to provide the employee's e employee's Average Weekly inployee or a beneficiary. However a similar employee veek period). "Wages" include ployee for personal services, and believ. dues to timely the a complete one' Compensation Act, Texas one' Compensation Act, Texas | The employer shall marrier proscribed by (1) The wage stale carrier, the datment, of the earliest of: (A) the employee (3) the date the income benefits; (C) the date of the days of receiving a read the employee knownation comained the employer dates on through a feet the days of receiving a read the employer dates and the employer dates on through a feet the days of the days of receiving a read the employer dates and the employer dates on through a feet the days of the | mant shall be filed ("filed" meens and the cisimant's representative (if any time cisimant's representative (if any time cisimant's representative (if any time cisimant shall also be filed with the Disquest from the Division (Only When the cisimant shall be filed with the previous wage statement if any within if on the provious wage statement thus exposurately wage statement. | end in the form and racelved) with the racelved) with the racelved with the racelved to expenses be injury. It is a cause, or amployee, eaven days if any changes (such as if age that was initially | |
| EMPLOYEE AND EMPLOYER IN | FORMATION | · · | | . | |
| Employee's Name (Last, First, M.I.): Suiter, Joey (b) (4) | g: | Employer's Business Name: CES Environmental Services Employer's Mailing Address (Street or P.O. Box): 4904 Griggs Rd | | | |
| City: State: (b) (4) | ZiP Cotfe: | ह्मारः Houston | State: ZIP | Code: | |
| Sector Sections Milmage | | Federal Tax J.D. Nun | TX ber: | 77021 | |
| (b) (4) | D=1 | 76-0592985 | | | |
| | 10 10 10 10 10 10 10 10 10 10 10 10 10 1 | KAN L A. C. | Person Providing Wage Information 132-287-08 | м: 45. | |
| As of today's date, the employee is not The employee returned to work on without restriction. OR with restrictions and is earning wage weak/month (circle one). NOTE - Rule 120.3 requires the employer file lightly (DWC FORM-5) to report changes in Eerrangs. | and is working: s of \$per the Supplemental Report of | compiles with the To and the listed wages (samed in) the 13 we and I understand | THAT this wage statement is com uses Workers' Compensation Aut e include all pecuniary and horsecu- sike prior to the date of injury (as d bet making a micropresentation a sorting that can result in fines and | nd applicable rules, nlary wages paid for escribed on page 2) | |
| EMPLOYMENT STATUS AT TIME | OF INJURY (Check A | (Il That Apply) | 7 | | |
| E Full-time: employee who regularly works least 30 hours per week and whose schedule comparable to other amployees of the comparable to other amployees in the same business vicinity who are considered full-time. Descent: employee who as regular course conduct engages in seasonal or cycli employment that may or may not be agriculture and that does not continue throughout year. | at Pert-time: Regular surpleyed whose work period preceding the injured worked period preceding the injured worked period preceding the injuries work during that period preceding the p | r Course of Condi- history for the 12-mo sy shows the person of het period. Ular Course of Condu- nistory for the 12-mo ry shows part-time and lod. | nth end not emercipated by a culon who is also an appropriate to the culon who is also an appropriate to the culon who is also an appropriate to the culon to the culon of technical and the culon of technical and the culon of technical and the culon of technical and the culon of technical and the culon of technical and the culon of technical and the culon of technical and the culon of the culo | narriage or judicial premites, traines or policy in a course of or other institute of training. Training. Terpoing systematic some articles or the property of the property of the property or the property or the property or the property or the property or the property or the property or the property or the property or the property or the property or the property or the property or the property or the property or the property or the property or the property of the property | |
| SAME OR SIMILAR EMPLOYEE? | | | ot employed for 13 continuous was | | |
| whose wages were provided.) | | or injury, report the waster a wages, compare to injury and a wages, compare to injure of the wages, representation of the wages, and injured employee print and a wages, and | ages of an employee who has its stable to the injured employee A able in nature and in number of its port the limited available wage or to the injury. | ining, experience, William ND who performs William Wil | |
| NOTE TO INJURED EMPLOYEE — If you were provide your insurance carrier with wege information or contact your carrier for additional information or | BUCK PURK YOUR CLEAN SHANINYA | HITE IST ING COMMENTAL IN | CNVC I - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - | - Mr | |
| DWC FORM-903 Ray, 19/05 | | | | Page (| |

RECEIVED TIME JAN. 29. 8:29AM

8:29AM

S ے:

| WAGE INF | ORMA | 1OIT | LINSTR | UCTION | S | Employee | Name: | oev S | utter | | Şodal Se | cusity #: | 01-08- | 2362 | ata of Injury | 127/18/08 |
|---|--|--------|-----------------------------|-----------------------------|-----------------------------|------------------------------|-----------------------|--------------------------------|---------------|-------------------------|--------------|-----------------|-----------------------------|--------------------------|--------------------------------|---|
| - The employs | et shall | report | all wage | s earned [| n the 13 t | weeks bro | nediately | preceding | the date | of Injury. | If the em | ployee is p | क्ष्यं का व ग | Ordiny O | sent-ment | ny basis, the |
| employer may | - The employer shall report all wages earned in the 13 weeks immediately preceding the date of injury. If the employee is paid on a monthly is sent-monthly basis, the employer may provide wages for the 3 months preceding the date of injury. Monthly wages may also be converted to weekly wages by dividing the gross monthly amount by 4.34821. If the employee is paid on a threekly basis, the employer may provide the wages for the 14 weeks preceding the date of injury. Attribute periods to provide the wages for the 14 weeks preceding the date of injury. Attribute periods to provide the wages for the 14 weeks preceding the date of injury. Attribute periods to provide the wages for the 14 weeks preceding the date of injury. | | | | | | | | | | | | | | | |
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| reporting 14 w | - If reporting weekly earnings, use all 13 Period Columns below. If reporting 3 months of earnings, either convert the wages to weekly earnings or use the first 3 Period Columns. If reporting 14 weeks of biweekly earnings, use the first 7 Period Columns. In all cases, indicate the dates that each period covers. | | | | | | | | | | | | | | | |
| Pecceptary Wagns include all wagns that are paid to the armioyee in the form of money. These include, but are not limited to: found, wendly, beneatly, monthly, etc. wages; salary, the practice; piecework compensation; monetary allowances; bonuses; and | | | | | | | | | | | | | | | | |
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| TO DATE: | 7/20 | 198 | 9/27/08 | 10/04/08 | 10/11/06 | 10/18/09 | 10/25/0 | 8 1 1/01/08 | 11/98/2008 | 11/15/08 | 11/22/08 | 11/29/08 | 12/06/08 | 12/13/08 | 122408 | TOTALS |
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| Lodging/ Housing! | | _ | 7 | | | | | | | | | | | | | |
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Gret w/Sylvian



6210 É Highway 290 Austin, Texas 78723-1098 (512) 224-3800 (FAX) 1-512-224-2866 P.O. Box 12058 Austin, Texas 78711-2058 1-800-859-5995 (FAX) 1-800-359-0650

November 26, 2008

VIA CERTIFIED MAIL 7008 2810 0000 3538 7460

C E S ENVIRONMENTAL SERVICES INC 4904 GRIGGS RD HOUSTON, TX 77021-320

Re:

Policy No.

0001086044

Policy Period:

1/25/2008 to 1/25/2009

Quote No.

Q000983818

Dear Policyholder:

As the state's leading provider of workers' compensation insurance, we strive to set the standard in Texas for service, communication, and ease of doing business. It has been our privilege to provide your workers' compensation insurance coverage during the past year.

Expiration Notification

Your existing policy with us will end on 1/25/2009. We are required by law to give you this notice. Texas Mutual Insurance Company values your business and looks forward to issuing you a renewal policy. We have also notified your insurance agent that the insurance coverage is ending and we will be working with them to obtain the necessary information to offer a quote for your renewal. It is important that you assist your agent by providing the information for Texas Mutual Insurance Company to offer a quote for new coverage. You failure to provide information and pay the renewal premium before your current policy ends will cause a lapse in coverage.

Loss History

The Texas Department of Insurance requires us to provide your loss history for the past 12 months. A loss history report will be provided to you under separate cover.

You may verify your loss history by logging on to <u>www.texasmutual.com</u> and clicking "Loss Run and Claim Detail", or by contacting $Texas\ Mutual_{\, @}$ in writing or calling 1-800-859-5995.

Thank you again for giving us the opportunity to serve as your workers' compensation company. We look forward to continuing our business relationship. In the meantime, if you have any questions, please contact your agent or call us at 1-800-859-5995.

Sincerely,

CYNDI PURTEE

Underwriting Department

cc: Houstoun woodard eason gentle tomforde & 1776 Yorktown #200 Houston, TX 77056



C E S ENVIRONMENTAL SERVICES INC 4904 GRIGGS RD HOUSTON, TX 77021-3208

Thank you for choosing Texas Mutual Insurance Company as your workers' compensation insurance carrier. We hope that you will choose us again at your policy renewal.

As of 11/26/2008, our records indicate you previously qualified for the following $Texas\ Mutual^{\oplus}$ dividend(s).

| | I ndividual |
|-------|--------------------|
| Year | Dividends* |
| 2008 | 27,783.74 |
| 2007 | |
| 2006 | 20,835.24 |
| 2005 | 9,858.26 |
| 2004 | 9,064.83 |
| 2003 | 3,307.36 |
| 2002 | 695.36 |
| Total | 71,544.79 |

Since 1999, we have paid over \$445 million in dividends to qualifying $Texas\ Mutual^{\circledR}$ policyholders. Our philosophy is to share our financial success with loyal customers when funds are available. (NOTE: Past dividends are not a guarantee of future dividends, and the Texas Department of Insurance must approve all dividend plans.)

We appreciate your business, and we value you as a customer. We hope we may continue our business relationship with you for many years to come.

For more information about $Texas\ Mutual^{\circledast}$ dividends, please visit our website's dividend page at: WWW.TEXASMUTUAL.COM/DIVIDENDS

DIVLTR-060107

^{*}Individual dividends reward individual policyholders retrospectively for their low claim losses and customer loyalty.



Supplemental Employee Data Worksheet

| Policyholder's name: | | Policy/quote no. | | | | |
|--|-------------------|------------------------|--|------------------------------------|----------------------------|--------------------------------------|
| Instructions: In order to he this form and return it as so and make additional copic assistance. | on as possibl | le. Use one i | row for ead | ch physical | business | location, |
| Physical address (no P.O. boxes) | City | State & ZIP Code | Building height (no. Of stories) | No. Of employees by location | No. Of work Shifts | Max no. Of employees per shift |
| 14904 Geigos Rd Houston TX Frozil | Houston | TX | | | | |
| 2. | | | | | | |
| 3. | | | | | | |
| 4. | | | | | | |
| 5. | | | | | | |
| 6. | | | | | | |
| 7. | | | | | | |
| 8. | | | | | | |
| 9. | | | | | | |
| 10. | | | | | | |
| Are there any special events du locations listed above, such as colf yes, please explain: | nventions, holida | ay parties, etc.? | Yes | D people at o | one time at (circle one | |
| Name of person completing form: Company name: | | | | Da | ite: cyholder (| Agent |
| | Please fax o | or mail complete | ed form to: | | | |

Texas Mutual Insurance Company P.O. Box 12058 Austin, Texas 78711-2058 (FAX) 1-800-359-0650

SUPPEDW (3/22/05)



UNITED STATES DEPARTMENT OF LABOR

SCAPA

Occupational Safety and Health Administration

Houston South Area Office 17625 El Camino Real, # 400 Houston, TX 77058

Telephone: (281) 286-0583 Fax: (281) 286-6352



4904 Griggs Road Phone: (713) 676-1460 Houston, TX 77021 Fax: (713) 676-1676

http://www.cesenvironmental.com

TCEQ Industrial Solid Waste Permit No: 30948 U.S. EPA ID No: TXD008950461 ISWR No: 30900

| SECTION 1: Gener | ator Informat | ion | | | | | | | | | | | | |
|---|----------------|-------------|--------------------|----------|--------------|-----------|--------------|-------------|--------|-------------|---------|----------|-----------|------|
| Company : | KMTEX | | | | | | | | | | | | | |
| Address : | 2450 South | Gulfwa | y Drive | РО Во | x 1421 | | | | | | | | - | |
| City, State, Zip : | Port Arthur | TX 776 | 41 | | | | | | | | | | | |
| Contact : | David | | | | | | | Title : | | | | | | |
| Phone No : | (409) 985-4 | 200 | | | | | | Fax: | (4 | 09) 985 | -6350 | | | |
| 24 / HR Phone : | | | | | | | | | _ | | | | | |
| U.S EPA I.D No : | TXD988076 | 3295 | | | | | | | | | | | | |
| State I.D : | 23491 | | | | | | | _SIC Co | de _ | | | | | |
| SECTION 2: Billing | Information | | | | | | | | | | | | | |
| Company : | KMTEX | | | | | | | | | | | | | |
| Address : | 2450 South | Gulfwa | y Drive | РО Во | x 1421 | | | | | | | | | |
| City, State, Zip: | Port Arthur | TX 7764 | - 11 | | | | | | | | | | | |
| Contact : | David | | | | | | | Title : | | | | | | |
| Phone No: | (409) 985-4 | 200 | | | | | | Fax: | (4 | 09) 985 | -6350 | | • | |
| SECTION 3: Gener | al Description | of the \ | Vaste | | | | | | | | | | | |
| Name of Waste : | Water from | distillati | on | | | | | | | | | | | |
| Detailed Descrip | tion of the F | rocess | Genera | ating W | aste: | | | | | | | | | |
| Liquids from distill recovered as prod | lation of MEk | | | _ | | the ma | nufactu | ıring of lu | be oil | and wa | xes. To | luene ai | nd MEK | were |
| Physical State : | ✓ Liqu | iid | | 👸 Slu | ıdge | | ₽ Po | wder | | | | | | |
| | <u></u> Soli | d | | ■ Fil | ter Cake | | Co | mbinatio | n | | | | | |
| Color : | | | | clear | | Od | or: | | | | slight | hydroca | arobn | |
| Specific Gravity (Water=1) : | | | 1 | | De | Density : | | | | 8 | | ! | lbs / gal | |
| Does this material | contain any t | otal phei | nolic co | mpound | s ? | ☐ Ye | es. | ✓ No | | | | | | |
| Does this material | contain any p | ara subs | stituted | phenoli | compo | unds? | [| Yes | [| √ No | | | | |
| s the Waste subjec | ct to the benz | ene was | te opera | ition NE | SHAP? (| 40 CFR F | Part 61, | Subpart | FF) | | Yes | | No | |
| · | 2816 2819 | 2821 | 2822 | 2823 | 2824 | 2833 | 2834 | 2835 | 2836 | 2841 | 2842 | 2843 | 2844 | 2851 |
| | 2869 2873 | | | | | | | 2896 | | | | | | 9511 |
| _ayers : | ✓ Sing | le-Pha | \$ | ∭ Mu | ılti-Phas | se | | | | | | | | |
| Container Type : | Drui | n 🗓 |] 1 | Γote | \checkmark | Truck | 2978 1372 | Other (| explai | n) | | - | | |
| Container Size : | 500 | 0 | | | | | | | | | | | | |
| Number Of Units | :8 | | | | | | | | | | | | | |
| Is this a USEPA "I If "Yes", then ple | | - | | | | ardous Co | | □ No | | d hereto | • | | | |
| , | | | | | | | | | | | | | | |

| Characteristic for Toxic Me | | _ | | 0007 | |
|---|-------------------------|---------------|----------------------------|-------------------------------|--|
| Characteristics for Toxic O | D008 | | | 0011 | |
| | | | | <u> </u> | |
| Is this an "F" or "K" Listed | | | | | |
| If "Yes", then please lis | st ALL applicable cod | les: | F005 | | |
| Is this a commercial produ 261.33(e) or (f)? | ict or spill cleanup ti | hat wo | uld carry a "U" or "P" was | te code under 40 CFR | Yes 🗸 No |
| If "Yes", then please li | st ALL applicable co | des: | | | |
| Texas State Waste Code I | No : 900 | 0219H | | | |
| Proper U.S. State Waste C | Code No : | | RQ Waste flammable | e liquids, n.o.s. (MEK, Tolue | ene) |
| Class: 3 | UN/NA : | 2924 | PG: | 11 | RQ: 100 |
| Flash Point | pН | | Reactive Sulfides | Reactive Cyanides | Solids |
| <140 | 5-9 | | brlmg/l | brl mg/l | 1-3 % |
| Oil and Grease | тос | - 1 | Zinc | Copper | Nickel |
| <1500 mg/l | brl | mg/l | brl mg/l | brl mg/l | brlmg/l |
| SECTION 4: Physical and Che | emical Data | | | | |
| | COMPONENTS | ARLE | | Concentration | on Units |
| | roduct consists of | | | Ranges are acce | A CONTRACTOR OF SECURITY OF SE |
| | water | | | 95-100 | % |
| | MEK | | | . 0-1 | % |
| | Toluene | -+ | | 0-1 1-3 | % % |
| | Dirt, sand, rus | 5 1 | | 1-3 | 70 |
| | | | | | |
| SECTION 5: Safety Related D | | | | | |
| If the handling of this was PPE for flammables | te requires the use | ofspe | ecial protective equipme | nt, please explain. | |
| FFE IOI IIAIIIIIIADIES | | | | | |
| | | | | | |
| SECTION 6: Attached Suppor | ting Documents | | | | |
| List all documents, notes, | | - sis atta | ched to this form as par | rt of the waste approval pa | ackage. |
| none | adia, arraior arraiy | oio ata | to the form 20 par | to the wood approval pe | wilder. |
| | | | | | |
| | | | | | |
| SECTION 7: Incompatibilities | | _ | | | |
| Please list all incompatibil | ities (if any): | | | | |
| none | | | | | |
| | | | | | |
| | | | | | |
| SECTION 8: Generator's Know Laboratory analysis of the | hazardous waste o | | teristics, listed below, W | AS NOT PERFORMED bas | sed upon the |
| following generators know | _ | | | | |
| TCLP Metals : | × | | | | |
| | <u>X</u> | | | | |
| TCLP Semi-Volatiles : | <u>x</u> | | | | |

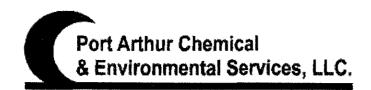
| Corro | sivity: <u>x</u> | | | | | | |
|----------|---|--|--|--|--|--|--|
| lgnita | bility: <u>x</u> | | | | | | |
| SECTI | ON 9: Waste Receipt Classification Under 40 CFR 437 | | | | | | |
| ls this | material a wastewater or wastewater sludge? YES NO | | | | | | |
| If 'YE | S', complete this section | | | | | | |
| PLEA | SE CHECK THE APPROPRIATE BOX: IF NO APPROPRIATE CATEGORY, GO TO THE NEXT PAGE | | | | | | |
| Matal | s Subcategory: Subpart A | | | | | | |
| | Spent electroplating baths and/or sludges | | | | | | |
| Γ_ | Metal finishing rinse water and sludges | | | | | | |
| | Chromate wastes | | | | | | |
| | Air pollution control blow down water and sludges | | | | | | |
| | Spent anodizing solutions | | | | | | |
| | Incineration wastewaters | | | | | | |
| | Waste liquid mercury | | | | | | |
| | Cyanide-containing wastes greater than 136 mg/l | | | | | | |
| | Waste acids and bases with or without metals | | | | | | |
| | Cleaning, rinsing, and surface preparation solutions from electroplating or phospha | | | | | | |
| | Vibratory deburring wastewater | | | | | | |
| | Alkaline and acid solutions used to clean metal parts or equipment | | | | | | |
| Oils S | ubcategory: Subpart B | | | | | | |
| | Used oils | | | | | | |
| | Oil-water emulsions or mixtures | | | | | | |
| | Lubricants | | | | | | |
| | Coolants | | | | | | |
| | Contaminated groundwater clean-up from petroleum sources | | | | | | |
| | Used petroleum products | | | | | | |
| \Box | Oil spill clean-up | | | | | | |
| | Bilge water | | | | | | |
| | Rinse/wash waters from petroleum sources | | | | | | |
| | Interceptor wastes | | | | | | |
| | Off-specification fuels | | | | | | |
| | Underground storage remediation wastes | | | | | | |
| | Tank clean-out from petroleum or oily sources | | | | | | |
| | Non-contact used glycols | | | | | | |
| | Aqueous and oil mixtures from parts cleaning operations | | | | | | |
| | Wastewater from oil bearing paint washes | | | | | | |
| Organ | ics Subcategory Subpart C | | | | | | |
| | Landfili leachate | | | | | | |
| | Contaminated groundwater clean-up from non-petroleum sources | | | | | | |
| | Solvent-bering wastes | | | | | | |
| <u>~</u> | Off-specification organic product | | | | | | |
| | Still bottoms | | | | | | |
| | Byproduct waste glycol | | | | | | |
| | Wastewater from paint washes | | | | | | |

Reactivity:

<u>X</u>

Wastewater from adhesive and/or epoxies formulation

| Tank clean-out from organic, non-petroleum sources | |
|---|--|
| (1) If the waste contains oil and grease at or in excess of 100 mg/L, the waste | should be classified in the oils subcategory |
| (2) If the waste contains oil and grease less than 100 mg/L, and has any of the excess of the values listed below, the waste should be classified in the me | |
| Cadmium: 0.2 mg/L Chromium: 8.9 mg/L Copper: 4.9 mg/L Nickel: 37.5 mg/L | |
| (3) If the waste contains oil and grease less than 100 mg/L, and does not have or nickel above any of the values listed above, the waste should be classified. | |
| ☐ Metals Subcatego | |
| ☐ Oils Subcatego | |
| ✓ Organics Subcategory | |
| SECTION 10: Additional Instruction | |
| Chromium, Copper, Nickel, and Oil and Grease, CES will send offsite to a com concentrations. This will be prior to acceptance. The generator will be respons SECTION 11: Generator's Certification | |
| The information contained herein is based on generator knowledge a above and attached description is complete and accurate to the best of modeliberate or willful omissions of composition properties exist and that all disclosed. I certify that the materials tested are representative of all materials disclosed. | ny knowledge and ability to determine that no ll known or suspected hazards have been erials described by this document. |
| Printed Name / Title : David Spacek / | Date . 9/24/2000 |
| CES USE ONLY (DO NOT WRITE IN THIS SPACE) | Process Facility Information : |
| Compliance Officer: Prabhakar Thangudu | |
| Date: 10/21/2008 Status: Approved Rejected | |
| Approval Number : HOU-3034 | |
| | 1 |



2420 S. Gulfway Dr. Port Arthur, TX 77641 Phone: (630) 212-0437

Fax: (713) 676-1676



то: Texas Mutual

From: Karl Guidry

713-676-1460

Fax:

512-224-3889

Pages: 2 Pages to follow

Attn:

Karen Crouse

Date:

February 3, 2009

Karen, I have updated Joey's wage report and included the non-pecuniary wage information. Under the "# hours worked" box, be advised that all hours over 40 are considered overtime. For the week of November 2, 2008, Joey did not work on Tuesday or Wednesday of that week, therefore decreasing his total number of hours reported for the week.

Please let me know if you have any additional questions.

Thanks

Karl Guidry CES Environmental Services, Inc. HSE Manager 4904 Griggs Rd Houston, Texas 777021

713-676-1460 713-676-1676 Fax kguidry@cesenvironmental.com ******* -IND. XMT Journal- ******** Date FEB-03-2009 **** Time 14:00 ******

Date/Time = FEB-03-2009 13:58

Journal No. = 168

Comm. Result = OK

Page(s) = 003

Duration = 00:00:58

File No. = 860

Mode

= Memory Transmission

Destination = 15122243889

Received ID =

Resolution = Fine

-CES ENVIROMENTAL

***** DP-C264 ************************

_ **** _

7137488664- *******

| WAGE INFORMAT | ION INSTRUC | TIONS | Empl | oyee Name: | loo | v Suttoi | Social Security # | 101 09 226 | Date of Injury: | 40/40/00 |
|---------------|-------------|-------|------|------------|------------|-----------------|-------------------|------------|-----------------|----------|
| | | | | | <u>JUG</u> | <u>y Quilei</u> | | 401-00-230 | <u> </u> | 12/10/00 |
| | | | | _ | | , | | | | |

- The employer shall report all wages earned in the 13 weeks immediately preceding the date of injury. If the employee is paid on a monthly or semi-monthly basis, the employer may provide wages for the 3 months preceding the date of injury. Monthly wages may also be converted to weekly wages by dividing the gross monthly amount by 4.34821. If the employee is paid on a biweekly basis, the employer may provide the wages for the 14 weeks preceding the date of injury. When setting the periods to report, the employer may adjust the reporting period backward slightly (up to six days) to line up the reporting timeframes with the employer's natural pay cycle. However, the employer shall not report wages earned on or after the date of injury.
- If reporting weekly earnings, use all 13 Period Columns below. If reporting 3 months of earnings, either convert the wages to weekly earnings or use the first 3 Period Columns. In all cases, indicate the dates that each period covers.

Pecuniary Wages include all wages that are paid to the employee in the form of money. These include, but are not limited to: hourly, weekly, biweekly, monthly, etc. wages; salary; tips/gratuities; piecework compensation; monetary allowances; bonuses; and commissions. Earnings are reported in the periods they are earned. NOT when they are paid and some (such as bonuses and **PECUNIARY WAGE INFORMATION** commissions) need to be prorated. Pecuniary wages don't include payments made by an employer to reimburse the employee for the use of the employee's equipment or for paying helpers or to reimburse for travel expenses. Consider as earnings amounts from paid holidays and any vacation, personal or sick leave an employee used but not the market value of leave time earned but not used. PERIOD # (Week #. 2 3 Month #, or Bi-Week #) FROM DATE: 09/14/08|9/21/08|09/28/08|10/05/08|10/12/08|10/19/08|10/26/08|11/02/08|11/09/08|11/16/08|11/23/08|11/30/08|12/7/08 TO DATE: 09/20/08 9/27/08 10/04/08 10/11/08 10/18/08 10/25/08 11/01/08 11/08/08 11/15/08 11/22/08 11/29/08 12/06/08 12/13/08 TOTALS # HOURS WORKED: 45.00 80.13 73.01 55.00 46.05 46.11 68.35 39.13 71.23 45.26 46.28 69.28 71.22 752.23 **GROSS WAGES EARNED:**

| Nonpecuniary Wage Type | Provide | Employer Specify Value Or Am Provided Prior To Injury? | | | | benefits listed below but do not include monetary allowances or stipends paid to allow the employed nount Earned in Each Reported Period For Each Benefit Provided Prior To Injury (Use the same periods as used above) | | | | | | | | Will Employer Continue To Provide? | | Date Benefit Suspended (if suspended) | | |
|---------------------------|----------|--|---|---|--------|---|---|---|----------|------------|------------|------------|-----------|--|----|---|----|------------|
| | YES | NO | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | YES | NO | 7 |
| Health Insurance | ✓ | | | | | | | | <u> </u> | no benefit | no benefit | na benefit | no benefi | (b) (4) | | | | 01/01/2009 |
| Laundry/ Cleaning | | | | - | - ! | | | | - | - | - | <u>-</u> | | | | | _ | |
| Clothing/ Uniforms | ✓ | - | | | | | | | - | (b) (4) | | | | | | | | |
| Lodging/ Housing/ | | | | | | | | | | | | | | | | |] | 1 |
| Food <i>i</i> Meals | | | | | | | | | | | | | | | | | | |
| Vehicle/ Fuel | | | | | | | _ | | | - | <u></u> | | | | | | 1 | |
| Other | | | | | | | | | | | | | | | | | 1 | |

NOTE: With few exceptions, you are entitled on request to be informed about the information that TDI-DWC collects about you. Under §\$52.021 and 552.023 of the Government Code, you are entitled to receive and review the information. Under §559.004 of the Government Code you are entitled to have TDI-DWC correct information about you that is incorrect. For more information, call the local TDI-DWC field office at 800-252-7031.

| Send to workers' compensation carrier: | | | | |
|--|--|--|--|--|
| (Name and fax number of carrier) | | | | |



| CLAIM# | 99J0000556027 | |
|---------|---------------|--|
| CARRIEF | 2'S CLAIM# | |

□ Initial □ Amended EMPLOYER'S WAGE STATEMENT (DWC Form-003)

The Texas Workers' Compensation Act and Workers' Compensation rules require an employer to provide an Employer's Wage Statement to its workers' compensation insurance carrier (carrier) and the claimant or the claimant's representative, if any. The purpose of the form is to provide the employee's wage information to the carrier for calculating the employee's Average Weekly Wage (AWW) to establish benefits due to the employee or a beneficiary.

The AWW is based on the wages the employee earned in the 13 weeks immediately preceding the date of injury (or the wage a similar employee earned if the employee did not work the full 13-week period). "Wages" include all forms of remuneration payable to an employee for personal services, including fringe benefits. To simplify filing, employers may file wages in a monthly, biweekly, or weekly manner as discussed below.

NOTE - An employer who fails without good cause to timely file a complete wage statement as required by the Texas Workers' Compensation Act, Texas Labor Code, Section 408.063(c) and Worker's Compensation Rule 120.4 may be assessed an administrative penalty.

The employer shall timely file a complete wage statement in the form and manner prescribed by the Division.

- (1) The wage statement shall be filed ("filed" means received) with the carrier, the claimant, and the claimant's representative (if any) within 30 days of the earliest of:
 - (A) the employee's eighth day of disability;
 - (B) the date the employer is notified that the employee is entitled to income benefits:
 - (C) the date of the employee's death as a result of a compensable injury.
- (2) The wage statement shall also be filed with the Division within seven days of receiving a request from the Division (Only When Requested).
- (3) A subsequent wage statement shall be filed with the carrier, employee, and the employee's representative (if any) within seven days if any information contained on the previous wage statement changes (such as if the employer discontinues providing a nonpecuniary wage that was initially continued after the date of injury).

| EMPLOYEE AND EMPLOYER INFORMATION Employee's Name (Last, First, M.I.): Sutter, Joey Employee's Mailing Address (Street or P.O. Box): Employee's Mailing Address (Street or P.O. Box): Employee's Mailing Address (Street or P.O. Box): Description | be assessed an administrative penalty. | | continued after the date of | | cuniary wage that was initially |
|---|---|---|--|--|---|
| Employee's Name (Last, First, M.I.): Sutter, Joey Employee's Maling Address (Street or P.O. Box): Employee's Maling Address (Street or P.O. Box): 4904 Griggs Rd City: State: ZIP Code: Houston TX 77021 State: As of today's date, the employee is not back at work. OR Inhe employee returned to work on and is working: without restriction. OR with restriction and is earning wages of \$ week/month (circle one). NOTE — Rule 120.3 requires the employee file the Supplemental Report of Injury (DWC FORM-6) to report changes in Work Status and Post-Injury Earnings. EMPLOYMENT STATUS AT TIME OF INJURY (Check All That Apply) EMPLOYMENT STATUS AT TIME OF INJURY (Check All That Apply) EMPLOYMENT STATUS AT TIME OF INJURY (Check All That Apply) State: ZIP Code: Houston TX 77021 HEREBY CERTIFY THAT this wage statement is complete, accurate, and complies with the Texas Workers' Compensation Act and applicable rules, and the listed wages include all pecuniary and nonpecuniary wages paid for (earned in) the 13 weeks prior to the date of injury (as described on page 2) and 1 understand that making a misrepresentation about a workers' compensation of the date of injury (as described on page 2) and 1 understand that making a misrepresentation about a workers' compensation of the date of injury (as described on page 2) and 1 understand that making a misrepresentation about a workers' compensation of the date of injury (as described on page 2) and 1 understand that making a misrepresentation about a workers' compensation of the date of injury (as described on page 2) and 1 understand that making a misrepresentation about a workers' compensation of the date of injury (as described on page 2) and 1 understand that the described on page 2) and 1 understand that making a misrepresentation about a workers' compensation of the date of injury (as described on page 2) and 1 understand that making a misrepresentation about a workers' compensation of the date of injury and or other instruction and practice in some and in the making and | | _ | All applicable DW | C rules can be found | d at www.tdi.state.tx.us |
| Employee's Name (Last, First, M.I.): Sutter, Joey Employee's Maling Address (Street or P.O. Box): Employee's Maling Address (Street or P.O. Box): 4904 Griggs Rd City: State: ZIP Code: Houston TX 77021 State: As of today's date, the employee is not back at work. OR Inhe employee returned to work on and is working: without restriction. OR with restriction and is earning wages of \$ week/month (circle one). NOTE — Rule 120.3 requires the employee file the Supplemental Report of Injury (DWC FORM-6) to report changes in Work Status and Post-Injury Earnings. EMPLOYMENT STATUS AT TIME OF INJURY (Check All That Apply) EMPLOYMENT STATUS AT TIME OF INJURY (Check All That Apply) EMPLOYMENT STATUS AT TIME OF INJURY (Check All That Apply) State: ZIP Code: Houston TX 77021 HEREBY CERTIFY THAT this wage statement is complete, accurate, and complies with the Texas Workers' Compensation Act and applicable rules, and the listed wages include all pecuniary and nonpecuniary wages paid for (earned in) the 13 weeks prior to the date of injury (as described on page 2) and 1 understand that making a misrepresentation about a workers' compensation of the date of injury (as described on page 2) and 1 understand that making a misrepresentation about a workers' compensation of the date of injury (as described on page 2) and 1 understand that making a misrepresentation about a workers' compensation of the date of injury (as described on page 2) and 1 understand that making a misrepresentation about a workers' compensation of the date of injury (as described on page 2) and 1 understand that making a misrepresentation about a workers' compensation of the date of injury (as described on page 2) and 1 understand that the described on page 2) and 1 understand that making a misrepresentation about a workers' compensation of the date of injury (as described on page 2) and 1 understand that making a misrepresentation about a workers' compensation of the date of injury and or other instruction and practice in some and in the making and | EMPLOYEE AND EMPLOYER INF | ORMATION | | | |
| Employee's Mailing Address (Street or P.O. Box): 4904 Griggs Rd City: State: ZIP Code: Houston TX 77021 Federal Tax I.D. Number: 76-0592985 As of today's date, the employee is not back at work. OR The employee returned to work on and is working: with out restriction. OR with restrictions and is earning wages of \$ week/month (circle one). NOTE - Rule 120.3 requires the employer file the Supplemental Report of Injury (Core Form-8) to report changes in Work Status and Post-Injury Eamings. Employee's Mailing Address (Street or P.O. Box): 4904 Griggs Rd City: State: ZIP Code: HOuston TX 77021 Federal Tax I.D. Number: 76-0592985 Name and Phope # of Person Providing Wage Information: And I runder Status Statement is complete, accurate, and complies with the Texas Workers' Compensation Act and applicable rules, and the listed wages include all pecuniary and nonpecuniary wages paid for (earned in) the 13 weeks prior to the date of injury (as described on page 2) and I understand, that making a misrepresentation about a workers' compensation farm is a firm-that can result in fines and/or imprisonment. Signature Employee whose work history for the 12-month period preceding the injury shows the person only worked part-time during that period. Part-time: Not Regular Course of Conduct: employee whose work history for the 12-month period preceding the injury shows part-time and full time work during that period. Part-time: Not Regular Course of Conduct: employee whose work history for the 12-month period preceding the injury shows part-time and full time work during that period. Part-time: Not Regular Course of Conduct: employee whose work history for the 12-month period preceding the injury shows part-time and full time work during that period. Part-time: Not Regular Course of Conduct: employee whose work history for the 12-month period preceding the injury shows part-time and full time work during that period. Part-time: Not Regular Course of Conduct: employee whose work history for the 12-month period | | | Employer's Business Nan | ne: | |
| Employee's Mailing Address (Street or P.O. Box): 4904 Griggs Rd City: State: ZIP Code: Houston TX 77021 Federal Tax I.D. Number: 76-0592985 As of today's date, the employee is not back at work. OR The employee returned to work on and is working: with out restriction. OR with restrictions and is earning wages of \$ week/month (circle one). NOTE - Rule 120.3 requires the employer file the Supplemental Report of Injury (Core Form-8) to report changes in Work Status and Post-Injury Eamings. Employee's Mailing Address (Street or P.O. Box): 4904 Griggs Rd City: State: ZIP Code: HOuston TX 77021 Federal Tax I.D. Number: 76-0592985 Name and Phope # of Person Providing Wage Information: And I runder Status Statement is complete, accurate, and complies with the Texas Workers' Compensation Act and applicable rules, and the listed wages include all pecuniary and nonpecuniary wages paid for (earned in) the 13 weeks prior to the date of injury (as described on page 2) and I understand, that making a misrepresentation about a workers' compensation farm is a firm-that can result in fines and/or imprisonment. Signature Employee whose work history for the 12-month period preceding the injury shows the person only worked part-time during that period. Part-time: Not Regular Course of Conduct: employee whose work history for the 12-month period preceding the injury shows part-time and full time work during that period. Part-time: Not Regular Course of Conduct: employee whose work history for the 12-month period preceding the injury shows part-time and full time work during that period. Part-time: Not Regular Course of Conduct: employee whose work history for the 12-month period preceding the injury shows part-time and full time work during that period. Part-time: Not Regular Course of Conduct: employee whose work history for the 12-month period preceding the injury shows part-time and full time work during that period. Part-time: Not Regular Course of Conduct: employee whose work history for the 12-month period | Sutter, Joev | | CES Environme | ental Service | es |
| City: State: ZIP Code: Houston TX 77021 State: State: ZIP Code: Houston TX 77021 State: State: ZIP Code: TX 77021 State: TX 77021 | | | | | |
| City: State: ZIP Code: Houston TX 77021 State: State: ZIP Code: Houston TX 77021 State: State: ZIP Code: TX 77021 State: TX 77021 | (b) (4) | | 4904 Griggs Rd | | |
| Touston Tous | | ZIP Cede: | | | ZIP Code: |
| Seasonal: employee who as regular course of conduct engages in the same business or vicinity who are considered full-time. Seasonal: employee who as regular course of conduct engages in seasonal or continue throughout the year. Seasonal: employee who as regular course of conduct engages in work thistory for the 12-month period preceding the angular deprendicular and the course of conduct engages in work or experiment that may or may not be agricultural in nature and that does not continue throughout the year. Date of Injury: | (b) (4) | | Houston | TX | 77021 |
| Date of Injury: 12/18/2008 | | | | , | |
| Date of Injury: 12/18/2008 As of today's date, the employee is not back at work. OR The employee returned to work on and is working: without restriction. OR with restrictions and is earning wages of \$ per week/month (circle one). NOTE - Rule 120.3 requires the employer file the Supplemental Report of Injury (DWC FORM-6) to report changes in Work Earnings. Part-time: employee who regularly works at least 30 hours per week and whose schedule is comparable to other employees of the company and/or other employees of the same business or vicinity who are considered full-time. Part-time: Not Regular Course of Conduct: employee whose work history for the 12-month period preceding the injury shows part-time and full time work during that period. Part-time: Not Regular Course of Conduct: employee enrolled in a course of student. Seasonal: employee whose agricultural in nature and that does not continue throughout the year. | (b) (4) | | 76-0592985 | | |
| As of today's date, the employee is not back at work. OR The employee returned to work on and is working: without restriction. OR with restrictions and is earning wages of \$ per week/month (circle one). NOTE - Rule 120.3 requires the employer file the Supplemental Report of Injury (DWC FORM-6) to report changes in Work Status and Post-Injury Earnings. Full-time: employee who regularly works at least 30 hours per week and whose schedule is comparable to other employees of the company and/or other employees in the same business or vicinity who are considered full-time. Seasonal: employee who as regular course of conduct engages in seasonal or cyclical employee whose work history for the 12-month period preceding the injury shows part-time and full time work during that period. Part-time: Not Regular Course of Conduct: employee whose work history for the 12-month period preceding the injury shows part-time and full time work during that period. Part-time: Not Regular Course of Conduct: employee whose work history for the 12-month period preceding the injury shows part-time and full time work during that period. Part-time: Not Regular Course of Conduct: employee whose some history for the 12-month period preceding the injury shows part-time and full time work during that period. Part-time: work during that period. Part-time: work during that period. Part-time: course of Conduct: employee whose work history for the 12-month period preceding the injury shows part-time and full time work during that period. Apprentice: employee whose work history for the 12-month period preceding the injury shows part-time and full time work during that period. Apprentice: employee whose work history for the 12-month period preceding the injury shows part-time and full time work during that period. Apprentice: employee who is learning a skilled trade or art by practical experience under the direction and practice in some art, trade or profession with a view towards proficiency in it. | | Injury: | Name and Phone # of Per | | |
| □ The employee returned to work on | 12/18 | 3/2008 | KARL Guida | 1 83 2-287 | -0862 |
| ☐ Full-time: employee who regularly works at least 30 hours per week and whose schedule is comparable to other employees of the company and/or other employees in the same business or vicinity who are considered full-time. ☐ Seasonal: employee who as regular course of conduct employment that may or may not be agricultural in nature and that does not continue throughout the year. ☐ Part-time: Regular Course of Conduct: employee less than 18 years of age and not emancipated by marriage or judicial employee whose work history for the 12-month period preceding the injury shows part-time and full time work during that period. ☐ Part-time: Regular Course of Conduct: employee less than 18 years of age and not emancipated by marriage or judicial action who is also an apprentice, trainee or student. ☐ Student: employee enrolled in a course of study in high school, college or other institute of higher education or technical training. ☐ Trainee: employee undergoing systematic instruction and practice in some art, trade or profession with a view towards proficiency in it. | The employee returned to work on without restriction. OR with restrictions and is earning wage: week/month (circle one). NOTE – Rule 120.3 requires the employer file Injury (DWC FORM-6) to report changes in | and is working: s of \$ per the Supplemental Report of | complies with the Texas and the listed wages inclu (earned in) the 13 weeks and I understand that compensation tham is a g | Workers' Compensa ude all pecuniary and prior to the date of in making a misrepre | tion Act and applicable rules, I nonpecuniary wages paid for njury (as described on page 2) esentation about a workers' in fines and/or imprisonment. |
| least 30 hours per week and whose schedule is comparable to other employees of the company and/or other employees in the same business or vicinity who are considered full-time. Seasonal: employee who as regular course of conduct engages in seasonal or cyclical employment that may or may not be agricultural in nature and that does not continue throughout the year. I employee whose work history for the 12-month period preceding the injury shows the person only worked part-time during that period. Part-time: Not Regular Course of Conduct: employee whose work history for the 12-month period preceding the injury shows part-time and full time work during that period. Apprentice: employee who is learning a skilled trade or art by practical experience under the direction of a skilled crafts person or artisan. Trainee: employee undergoing systematic instruction and practice in some art, trade or profession with a view towards proficiency in it. | EMPLOYMENT STATUS AT TIME | OF INJURY (Check A | All That Apply) | <u> </u> | |
| conduct engages in seasonal or cyclical employment that may or may not be agricultural in nature and that does not continue throughout the year. Description preceding the highly shows partitine and that grades are made to the highly shows partitine and that grades are made to the highly shows partitine and that the work during that period. Description preceding the highly shows partitine and that time work during that period. Description preceding the highly shows partitine and that time work during that period. Description preceding the highly shows partitine and that time work during that period. Description preceding the highly shows partitine and that time work during that period. Description preceding the highly shows partitine and that time work during that period. Description preceding the highly shows partitine and that time work during that period. Description preceding the highly shows partitine and that time work during that period. Description preceding the highly shows partitine and that time work during that period. Description preceding the highly shows partitine and that time work during that period. Description preceding the highly shows partitine and that time work during that period. Description preceding the highly shows partitine and that time work during that period. Description preceding the highly shows partitine and that time work during that period. Description preceding the highly shows partitine and that time work during that period. Description preceding the highly shows partitine and that time work during that period. Description preceding the highly shows partitine and that time work during that period. Description preceding the highly shows partitine and that time work during that period. Description preceding the highly shows partitine and that time work during the highly shows partitine and the highly shows partitine and the highly shows partition. | least 30 hours per week and whose schedule comparable to other employees of the compa and/or other employees in the same business vicinity who are considered full-time. | and not emancipated by marriage or judi action who is also an apprentice, trainee student. gular Course of Conduct: history for the 12-month study in high school, college or other institute. | | | |
| SAME OR SIMILAR EMPLOYEE? | conduct engages in seasonal or cycli- employment that may or may not be agricultural nature and that does not continue throughout t | riod. ee who is learning a skilled cal experience under the is person or artisan. | ☐ Trainee: emplinstruction and properssion with a v | oloyee undergoing systematic ractice in some art, trade or riew towards proficiency in it. | |

SAME OR SIMILAR EMPLOYEE?

The wage information on this form is for:

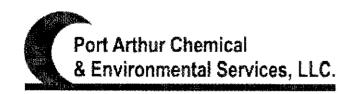
☑ The Injured Employee OR ☐ A Similar Employee (NOTE – If requested by the Division, the employer shall identify the similar employee whose wages were provided.)

If the employee was not employed for 13 continuous weeks before the date of injury, report the wages of an employee who has training, experience, skills & wages comparable to the injured employee AND who performs services/tasks comparable in nature and in number of hours. If no similar employee exists, report the limited available wages earned by the injured employee prior to the injury.

NOTE TO INJURED EMPLOYEE – If you were injured on or after 7/1/02, and had employment with more than one employer on the date of injury, you can provide your insurance carrier with wage information from your other employment for the carrier to include in your AWW and this may affect your benefits. Contact your carrier for additional information or call the Division at (800) 252-7031. You can also read rule 122.5 at www.tdi.state.tx.us/wc/rules/.

DWC FORM-003 Rev. 10/05

Page !



2420 S. Gulfway Dr. Port Arthur, TX 77641 Phone: (630) 212-0437

Fax: (713) 676-1676

USDOL OSHA To:

From:

Karl Guidry

Mobile (832) 287-0862

Fax:

281-286-6352

Pages: 2 Pages to follow

Attn:

Kimi Scarpa

Date:

January 14, 2009

See attached requested documentation.

Karl Guidry CES Environmental Services, Inc. **HSE Manager** 4904 Griggs Rd Houston, Texas 777021

713-676-1460 Ext 115 713-676-1676 Fax kguidry@cesenvironmental.com ****** -IND. XMT Journal- ********** Date JAN-14-2009 **** Time 14:00 *******

Date/Time = JAN-14-2009 13:59

Journal No. = 015

Comm. Result = OK

Page(s) = 003

Duration = 00:00:33

File No. = 518

Mode = Memory Transmission

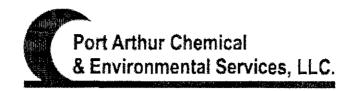
Destination = 2812866352

Received ID = /

Resolution = Fine

-CES ENVIROMENTAL -

**** DP-C264 *********** - - **** - 7137488664- *******



2420 S. Gulfway Dr. Port Arthur, TX 77641 Phone: (630) 212-0437 Fax: (713) 676-1676

Procedures for loading and unloading trailers

• LOADING TRAILERS:

- Ensure driver pulls trailer correctly and safely to loading area.
- The paperwork for loading the trailer will be in the Lab in the hanging box labeled outbound loads or the driver may have them with him.
- The operator will ensure that the proper product is being loaded into the proper trailer.
 If there are any discrepancies or confusion, the operator must check with the Logistics
 Manager before any transfers are made.
- Once verified, the operator will ground the trailer and ensure that the driver has chocked the wheels.
- The operator will don a respirator, bleed pressure, and open the man way on top to confirm that the trailer is empty. (All personnel will have a respirator on when opening any dome lid)! No Exceptions.
- Once confirmed, the operator will hook up the vapor exchange line to the tank being unloaded.
- The Driver MUST be in full PPE and safety watch the operator during the entire loading process and assist the operator when asked.
- The operator will load the trailer and visually check in the man way to ensure the trailer is filled to the correct capacity. Close and lock down the man way.
- Once the transfer is complete, blow down and unhook loading hoses, and transfer hose.

• The Driver is to inspect the trailer before moving. The driver is responsible for ensuring that the trailer is properly sealed and ready for transport.

• UNLOADING TRAILERS:

- Absolutely no trailers are to be unloaded without the proper paperwork, a sample taken, and the profile verified in the lab.
- Will follow same safety procedures as explained in the loading section.
- The driver will stay in the loading area in PPE throughout the duration of the transfer and assist if needed.

UNITED STATES OF AMERICA

DEPARTMENT OF LABOR

OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION

SUBPOENA DUCES TECUM

TO: CUSTODIAN OF RECORDS FOR Port Arthur Chemical and Environmental Services

Pursuant to Section 8 (b) of the Occupational Safety and Health Act (29 U.S.C.§657 (b)) you are hereby required to appear before the Mark R. Briggs, Area Director or his designee of the OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION, UNITED STATES DEPARTMENT OF LABOR, at 17625 El Camino Real, Suite 400 in the City of Houston, Texas 77058 on the 27th day of January, 2009, at 1:00 p.m. on that day, to produce records regarding the working conditions at Port Arthur Chemical and Environmental Services.

You are hereby required to bring with you and produce at said time and place the following items: as specifically described in Attachment A, items 1 through 21, which is made a part of this subpoena.

Whether or not form is specified in the individual requests below, the terms "document" and "record" shall each mean any written, printed, typed, photographic or other graphic matter or material of any kind or nature and all mechanical or electronic sound or video recordings or transcripts thereof, in the possession, custody and/or control of the Respondent or known by the Respondent to exist, and shall also mean all copies of documents by whatever means made, including, but not limited to, papers, letters, correspondence, accident/incident reports, photographs, video recordings, audio recordings, digital recordings, drawings, sketches, maps, diagrams, interoffice communications, emails or other electronically-sent messages, memoranda, notes, notations, notebooks, reports, records, accounting books or records, schedules, tables, charts, transcripts, publications, scrapbooks, diaries, and any drafts, revisions or amendments of the above.

FAIL NOT AT YOUR PERIL

IN TESTIMONY WHEREOF I have hereunto affixed my signature and the seal of the UNITED STATES DEPARTMENT OF LABOR at Houston, Texas this 20th day of January, 2009.

Kelly Knighton, Assistant Area Director

OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION

UNITED STATES DEPARTMENT OF LABOR

U.S. Department of Labor

Occupational Safety & Health Administration

Houston South Area Office 17625 El Camino Real Suite 400 Houston, Texas 77058 281/286-0583 Fax:281/286-6352

20 January 2009

Mr. Karl Guidry HSE Manager Port Arthur Chemical and Environmental Services 2420 South Gulfway Dr. Port Arthur, TX 77640

SUBJECT:

OSHA Document Request SUBPOENA #1

INSPECTION NUMBER 311960975

Dear Mr. Guidry:

In order to facilitate the inspection, following documents in Attachment A are being requested by OSHA. Please provide the documents on or before 27 January 2009.

Submit all items with a notation as to which document request item number each satisfies. Items already submitted in full shall be addressed as such in a written letter. Should you have any questions, please contact our office at (281) 286-0583. Thank you for your time and cooperation in this matter.

Sincerely.

Kelly Knighton

Assistant Area Director HSAO

OSHA- Document Request SUBPOENA #1 COMPANY: Port Arthur Chemical and Environmental Services

INSPECTION #: 311960975

REQUESTED DATE: 20 January 2009

Return of Service

| I hereby certify that on the _ | day of | 200 <u>9</u> , |
|---|-----------------------------------|----------------|
| for inspection number: | <u>311960975</u> , | |
| that the within subpoena was | served upon: | |
| Port Arthur Chemical (Comp | and Environmental Services oany) | _3 |
| by delivering it in person to _ | (Printed nam | e) |
| at | | |
| | (Location) | |
| | | |
| Compliance Safety and Healt | h Officer | |
| U.S. Department of Labor Occupational Safety and Hea | lth Administration | |
| | | |
| Employer Representative | | |

OSHA- Document Request SUBPOENA #1

COMPANY: Port Arthur Chemical and Environmental Services

INSPECTION #: 311960975

REQUESTED DATE: 20 January 2009

Instructions:

- 1. Documents responsive to each request shall be identified and produced by reference to the request number and/or subpart to which they are responsive.
- 2. Unless otherwise stated, the requests are for original documents. Copies may be produced in lieu of originals where certification is made that the copy is a true and accurate reproduction of the original.
- 3. The custodian need not appear in person to testify under oath if all documents are accompanied by an affidavit or declaration certifying that a reasonably diligent search was completed and that all documents responsive to the subpoena have been provided, or, in the alternative, that there are no documents responsive to the request.
- 4. Identify each document withheld from production on the grounds that the document contains materials for which a claim for privilege is asserted. The identification shall include the name, address, position, and organization of the author, each recipient of the document, the custodian of the document, the date of document, a brief description of the type of subject matter the document contains, and the request to which the document is responsive. The claim of privilege also shall include sufficient information to permit a Court to make a determination on the record as to whether the claim of privilege is valid.
- 5. Each request set forth herein refers to documents and property in custody, control, or possession of **Port Arthur Chemical and Environmental Services** or counsel, representatives, agents, servants, employees, investigators or consultants.

DEFINITIONS

- 1. "You" and "your" mean Port Arthur Chemical and Environmental Services.
- 2. "And/or" shall be construed conjunctively and disjunctively so as to acquire the broadest answer to the particular interrogatory. Similarly, "any," "each" and "every" are used in the inclusive sense, and therefore should be read as meaning "each and every."
- 3. "Document" means any writings of any kind, including the original and non-identical copies, including without limitation any correspondence, memoranda, notes, diaries, statistics, letters, materials, orders, directives, interviews, telegrams, minutes, reports, studies, statements, transcripts, summaries, pamphlets, books, interoffice and intra office communications, notations of any sort of conversation of telephone calls or meetings or other communications, bulletins, printed matter, teletype, telefax, worksheets, and all drafts, alterations, modifications, changes or amendments of any kind, including without limitations

OSHA- Document Request SUBPOENA #1

COMPANY: Port Arthur Chemical and Environmental Services

INSPECTION #: 311960975

REQUESTED DATE: 20 January 2009

any photograph, chart, graph, microfiche, microfilm, videotape records, motion pictures, electronic, mechanical or electrical recordings or representations of any kind including without limitation any tapes, cassettes, cartridges, disk, chip and records.

4. Terms of art (e.g., process, process hazard analysis) are defined in 29 C.F.R. 1910.119(b)

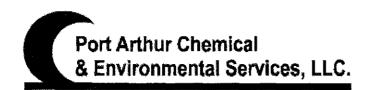
OSHA- Document Request SUBPOENA #1 COMPANY: Port Arthur Chemical and Environmental Services

INSPECTION #: 311960975

REQUESTED DATE: 20 January 2009

ATTACHMENT A

| Item | Description | Date received |
|------|---|------------------|
| 1 | Injury & Illness logs (OSHA 300& 300A) for the past 3 years | |
| | Bill of ladings for the last 11 loads received prior to the 18 December | |
| 2 | 2008 incident | |
| 3 | Document showing all employees | |
| | MSDS for any and all process chemicals at the Port Arthur Chemical | |
| 4 | and Environmental Services facility | |
| 5 | Copy of placard on the truck involved with the 18 December 2008 incident | |
| 6 | Document showing the witnesses of the 18 December 2008 incident | |
| 7 | Copy of the coroners report | |
| 8 | Written procedures for sampling the trailers as it existed at the time of the incident on 18 December 2008 | |
| 9 | PPE (personal protective equipment) assessment & certification | |
| | PPE requirements for taking samples of the trailers as it existed at the | |
| 10 | time of the incident on 18 December 2008 | |
| 11 | Written Respiratory Protection Program | |
| 12 | Hydrogen sulfide program/practices | |
| 13 | Written disciplinary program/ policy | , |
| 14 | All near misses and incident reports for 2008 | |
| 15 | Specific sampling procedures for extracting samples from trailers as it existed at the time of the incident on 18 December 2008 | |
| 16 | The 18 December 2008 sample analysis of the contents of the trailer (#267) | |
| .0 | Written process overview explaining the processes at the Port Arthur | |
| 17 | Chemical & Environmental Services site | 1 |
| | Process flow diagram for the processes at the Port Arthur Chemical & | |
| 18 | Environmental Services site | |
| | P&Ids (piping and instrumentation drawings) for the processes at the | |
| 19 | Port Arthur Chemical & Environmental Services site | |
| 20 | Any and all batch records for the processes from 16 December 2008 to 19 December 2008 | |
| | Any and all pH readings for the processes from 16 December 2008 to 19 | |
| 21 | December 2008 | |



2420 S. Gulfway Dr. Port Arthur, TX 77641 Phone: (630) 212-0437

Fax: (713) 676-1676



то: Texas Mutual

From: Karl Guidry

713-676-1460

Fax: 512-224-3889

Pages: 2 Pages to follow

Attn: Karen Crouse

Date: January 29, 2009

See attached requested documentation regarding our employee Joey Sutter. The wage statement was faxed in the documents on January 14, 2009.

Karl Guidry CES Environmental Services, Inc. HSE Manager 4904 Griggs Rd Houston, Texas 777021

713-676-1460 713-676-1676 Fax kguidry@cesenvironmental.com ******* -IND. XMT Journal- ********** Date JAN-29-2009 **** Time 08:23 *******

Date/Time = JAN-29-2009 08:21

Journal No. = 099

Comm. Result = OK

Page(s) = 004

Duration = 00:01:43

File No. = 789

Mode

= Memory Transmission

Destination = 15122243889

Received ID =

Resolution = Fine

-CES ENVIROMENTAL -

***** DP-C264 *************

_ **** _

7137488664- ******



| CLAIM# | 99J0000556027 |
|-----------|---------------|
| Carrier # | TEXAS MUTUAL |
| ł | |

SUPPLEMENTAL REPORT OF INJURY

| Part I EMPLOYER INFORMATION | <u> </u> | | | | | | | |
|--|-----------------------------------|---|-----------------------|-------------------------------|--|--|--|--|
| 1. Employer business name | 000 4000 | | 2. Employer pho | | | | | |
| CES ENVIRONMENTAL | SERVICES | | 713-676- | ·1460 | | | | |
| Employer mailing address 4904 GRIGGS RD. | | | | | | | | |
| 4. Insurance carrier name | | | | | | | | |
| TEXAS MUTUAL | | | | | | | | |
| Does the employer have return to work (| RTW) opportunities available | hased on the injured work | er's current canabili | ities? yes no 🗸 | | | | |
| If so, identify contact person and phone # | | | | | | | | |
| 6. Has the insurance carrier provided RTW coordination services within the past 12 months? yes Date no | | | | | | | | |
| 7. Has the employer requested RTW trainin | g from DWC or the insurance | carrier? yes | | no 🗸 | | | | |
| Has the insurance carrier provided accide | ent prevention services in the | past 12 months? yes | Date | no ✓ | | | | |
| Has the employer requested accident pre | vention services from the ins | urance carrier? yes [| | no 🗸 | | | | |
| Part II REASON FOR FILING THIS | REPORT (deadlines | vary, see instruction | s) | | | | | |
| 10. a. The injured worker returned t | o work in either a full or limite | d capacity: File this report | within 3 days. | | | | | |
| b. The injured worker is earning | more or less than the pre-inj | ury wage because of the in | jury: File within 10 | days. | | | | |
| c. The injured worker returned, | then later had additional lost t | time or reduced wages as a | result of the injury | : File within 3 days. | | | | |
| d. The injured worker resigned | <u> </u> | yment: File within 10 days | | | | | | |
| Part III INJURED WORKER INFOR | RMATION | AQ CONT (land delinita) | | 140 501 | | | | |
| 11. Injured worker name JOEY SUTTER | | 12. SSN (last 4 digits) XXX-XX-b) (4 | 4) | 13. DOI 12/18/08 | | | | |
| 14. Injured worker mailing address and phon | e# | AAA AA | | 12/10/00 | | | | |
| (b) (4) | | | | | | | | |
| 15. First day of lost time or reduced wages for this injury (mm/dd/yyyy) | | 16. First day of additional or reduced wages (n | | | | | | |
| 17, Has the injured worker experienced 8 da | ys (cumulative) of lost time or | reduced wages as a result | t of the injury? | yes no | | | | |
| If yes, the date of the 8th day (mm/dd/yyy | y) <u>NA</u> | | | | | | | |
| 18. Date of most recent RTW NA | 19. Has the injured worker | resigned, been terminated | or died? | yes 🚺 no 🔲 | | | | |
| Full duty, full pay | date of resignation | date of terminatio | n (| date of death <u>12/18.09</u> | | | | |
| Limited duty, full pay | 19a. Reason for resignation | | | | | | | |
| Limited duty, reduced pay | 19b. Was the injured worker | r on limited duty when term | inated? | yes no | | | | |
| 20. Hours the injured worker was working du | ring the pay period of | 21. Weekly/hourly earning | ngs for the pay perio | od of 12-14-08 | | | | |
| 7:00 AM to 4:00 PM : 40 hours per week to 12-20-08 : \$ (b) (4) weekly or \$ | | | | | | | | |
| Indicated hours are: | | Indicated wages are: | | | | | | |
| Increase from pre-injury Increase from pre-injury wage | | | | | | | | |
| Same as pre-injury wage | | | | | | | | |
| Decrease from pre-injury Decrease from pre-injury wage | | | | | | | | |
| This form to be filed with: The employer's insurance carrier and the injured worker in the timeframe as noted in Part II. | | | | | | | | |
| 22. To the best of my knowledge the information provided in this report is accurate and may be relied upon for evaluation of eligibility for benefits. | | | | | | | | |
| Submitted by: Image: Submitted by: Employer Image: Injury occurred.) | | | | | | | | |
| | | | | | | | | |
| KNII I HS | Manager | /- | -29-09 | ı | | | | |
| Signature and Title of person completing this for | orm | Date | · · · · · · · / | | | | | |
| 1 | | | | | | | | |



DWC FORM-6 (Rev. 10/05) Page 1

DIVISION OF WORKERS' COMPENSATION

| Send to workers' compensation carrier: | | | | |
|--|--|--|--|--|
| (Name and fax number of carrier) | | | | |



| CLAIM# |
|------------------|
| CARRIER'S CLAIM# |

☐ Initial ☐ Amended EMPLOYER'S WAGE STATEMENT (DWC Form-003)

The Texas Workers' Compensation Act and Workers' Compensation rules require an employer to provide an Employer's Wage Statement to its workers' compensation insurance carrier (carrier) and the claimant or the claimant's representative, if any. The purpose of the form is to provide the employee's wage information to the carrier for calculating the employee's Average Weekly Wage (AWW) to establish benefits due to the employee or a beneficiary.

The AWW is based on the wages the employee earned in the 13 weeks immediately preceding the date of injury (or the wage a similar employee earned if the employee did not work the full 13-week period). "Wages" include all forms of remuneration payable to an employee for personal services, including fringe benefits. To simplify filing, employers may file wages in a monthly, biweekly, or weekly manner as discussed below.

NOTE - An employer who fails without good cause to timely file a complete wage statement as required by the Texas Workers' Compensation Act, Texas Labor Code, Section 408.063(c) and Worker's Compensation Rule 120.4 may be assessed an administrative penalty.

The employer shall timely file a complete wage statement in the form and manner prescribed by the Division.

- (1) The wage statement shall be filed ("filed" means received) with the carrier, the claimant, and the claimant's representative (if any) within 30 days of the earliest of:
 - (A) the employee's eighth day of disability;
 - (B) the date the employer is notified that the employee is entitled to income benefits;
 - (C) the date of the employee's death as a result of a compensable injury.
- (2) The wage statement shall also be filed with the Division within seven days of receiving a request from the Division (Only When Requested).
- (3) A subsequent wage statement shall be filed with the carrier, employee, and the employee's representative (if any) within seven days if any information contained on the previous wage statement changes (such as if the employer discontinues providing a nonpecuniary wage that was initially continued after the date of injury).

| | | | All applicable DW0 | rules can be found | d at www.tdi.state.tx.us | |
|--|-----------------------|-----------------|--|---|--|--|
| EMPLOYEE AND E | MPLOYER INFOR | RMATION | | | | |
| Employee's Name (Last, Firs | | | Employer's Business Nan | ne: | | |
| Sutter, Joey | | | CES Environme | ental Service | es | |
| Employee's Mailing Address | (Street or P.O. Box): | | Employer's Mailing Addre | ss (Street or P.O. Bo | x): | |
| (b) (4) | | | 4904 Griggs Rd | | | |
| City: | State: | ZIP Code: | City: | State: | ZIP Code: | |
| (b) (4) | | | Houston | TX | 77021 | |
| | 1 | | Federal Tax I.D. Number: | | | |
| (b) (4) | | | 76-0592985 | | | |
| Ligate of Filine: | Date of Injur | ry; | Name and Phone # of Per | son Providing Wage | Information: | |
| (b) (4) | 12/18/2 | 008 | KARL A. Guic | lry 832-2 | 87-0862 | |
| As of today's date, the employee is not back at work. OR The employee returned to work on and is working: without restriction. OR with restrictions and is earning wages of \$ per week/month (circle one). NOTE - Rule 120.3 requires the employer file the Supplemental Report of Injury (DWC FORM-6) to report changes in Work Status and Post-Injury Earnings. | | | I HEREBY CERTIFY THAT this wage statement is complete, accurate, and complies with the Texas Workers' Compensation Act and applicable rules, and the listed wages include all pecuniary and nonpecuniary wages paid for (earned in) the 13 weeks prior to the date of injury (as described on page 2) and I understand that making a misrepresentation about a workers' compensation claim is a crime that can result in fines and/or imprisonment. Signature: Date: 1-29-49 | | | |
| EMPLOYMENT STA | TUS AT TIME OF | INJURY (Check A | III That Apply) | 7 | | |
| ☐ Full-time: employee who regularly works at least 30 hours per week and whose schedule is comparable to other employees of the company and/or other employees in the same business or vicinity who are considered full-time. ☐ Seasonal: employee who as regular course of conduct engages in seasonal or cyclical employment that may or may not be agricultural in nature and that does not continue throughout the part of the continue throughout the process of the company worked part-time: Regular employee whose work period preceding the injurity time work during that period preceding the injurity employees whose work period preceding the injury employees whose work period preceding the injury employees whose work period preceding the injury employees whose work period | | | r Course of Conduct: history for the 12-month ary shows the person only hat period. ular Course of Conduct: history for the 12-month ry shows part-time and full lod. see who is learning a skilled all experience under the | and not emancipal action who is als student. Student: emp study in high school higher education of trainee: emp instruction and pro- | vee less than 18 years of age ated by marriage or judicial so an apprentice, trainee or sloyee enrolled in a course of ol, college or other institute of r technical training. Sloyee undergoing systematic actice in some art, trade or lew towards proficiency in it. | |
| SAME OR SIMILAR | EMPLOYEE? | | If the employee was not as | unlayed for 12 contin | nuous weeks before the date | |

The wage information on this form is for:

☑ The Injured Employee OR ☐ A Similar Employee (NOTE – If requested by the Division, the employer shall identify the similar employee whose wages were provided.)

If the employee was not employed for 13 continuous weeks before the date of injury, report the wages of an employee who has training, experience, skills & wages comparable to the injured employee AND who performs services/tasks comparable in nature and in number of hours. If no similar employee exists, report the limited available wages earned by the injured employee prior to the injury.

NOTE TO INJURED EMPLOYEE — If you were injured on or after 7/1/02, and had employment with more than one employer on the date of injury, you can provide your insurance carrier with wage information from your other employment for the carrier to include in your AWW and this may affect your benefits. Contact your carrier for additional information or call the Division at (800) 252-7031. You can also read rule 122.5 at www.tdi.state.tx.us/wc/rules/.



DWC FORM-003 Rev. 10/05

Page I

| | Employee Name: | | Social Security #: | Date of Inju | irv: |
|--|-----------------------------|------------------------|----------------------------|------------------------|------------------|
| WAGE INFORMATION INSTRUCTIONS | Joey S | Sutter | 401-0 | 08-2362 | 12/18/08 |
| - The employer shall report all wages earned in the 13 | weeks immediately precedi | ng the date of injury. | If the employee is paid or | n a monthly or semi-mo | nthly basis, the |
| amployer may provide wares for the 3 months preceding | the date of injury. Monthly | wares may also be con | werted to weekly wages by | dividing the gross mor | thly amount by |

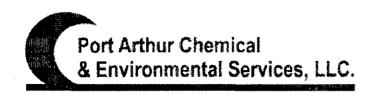
employer may provide wages for the 3 months preceding the date of injury. Monthly wages may also be converted to weekly wages by dividing the gross monthly amount by 4.34821. If the employee is paid on a biweekly basis, the employer may provide the wages for the 14 weeks preceding the date of injury. When setting the periods to report, the employer may adjust the reporting period backward slightly (up to six days) to line up the reporting timeframes with the employer's natural pay cycle. However, the employer shall not report wages earned on or after the date of injury.

- If reporting weekly earnings, use all 13 Period Columns below. If reporting 3 months of earnings, either convert the wages to weekly earnings or use the first 3 Period Columns. In all cases, indicate the dates that each period covers.

| PECUNIARY WAGE I | INFORM <i>A</i> | ATION | | hourly, we commissio commissio use of the | ekly, biweek ons. Eaming ons) need to employee's | kly, monthly gs are repo be prorated equipment o | y, etc. wages orted in the l I. Pecuniary or for paying | s; salary; tip: periods they wages don | es/gratuities; y are earned 't include pay to reimburse | piecework d, NOT who yments mad e for travel o | compensation they are le by an emperor control of the control of t | pn; monetar paid and soloyer to rein Consider as | y allowances ome (such a mburse the e earnings am | re not limited to: s; bonuses; and as bonuses and employee for the nounts from paid not used. |
|---|-----------------|----------|----------|--|---|---|--|--|--|---|--|--|--|---|
| PERIOD # (Week #, Month #, or Bi-Week #) | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | |
| FROM DATE: | 9/21/08 | 9/28/08 | 10/05/08 | 10/12/08 | 10/19/08 | 10/26/08 | 11/02/08 | 11/09/08 | 11/16/08 | 11/23/08 | 11/30/08 | 12/7/08 | 12/14/08 | |
| TO DATE: | 9/27/08 | 10/04/08 | 10/11/08 | 10/18/08 | 10/25/08 | 11/01/08 | 11/08/2008 | 11/15/08 | 11/22/08 | 11/29/08 | 12/06/08 | 12/13/08 | 12/24/08 | TOTALS |
| # HOURS WORKED: | 80.13 | 73.01 | 55.00 | 46.05 | 46.11 | 68.35 | 39.13 | 71.23 | 45.26 | 46.28 | 69.28 | 71.22 | 41.18 | 752.23 |
| GROSS WAGES EARNED: | (b) (4) | | | | | | | | | | | | | |

Nonpecuniary Wages include all wages paid to the employee in a form other than money. These include, but are not limited to, the NONPECUNIARY WAGE INFORMATION benefits listed below but do not include monetary allowances or stipends paid to allow the employee to purchase the benefits. Employer Specify Value Or Amount Earned in Each Reported Period For Each Benefit Provided Prior To Injury Will Employer Date Benefit Nonpecuniary Wage Type Provided Prior Continue To Suspended (Use the same periods as used above) To Injury? Provide? (if suspended) YES NO 2 3 5 10 11 12 13 YES NO Health 01/01/2009 Insurance Laundry/ Cleaning Clothing/ Uniforms Lodging/ Housing/ Food/ Meals Vehicle/ Fuel Other

NOTE: With few exceptions, you are entitled on request to be informed about the information that TDI-DWC collects about you. Under §\$552.021 and 552.023 of the Government Code, you are entitled to receive and review the information. Under §559.004 of the Government Code you are entitled to have TDI-DWC correct information about you that is incorrect. For more information, call the local TDI-DWC field office at 800-252-7031.



2420 S. Gulfway Dr. Port Arthur, TX 77641 Phone: (630) 212-0437

Fax:

(713) 676-1676



To:

Texas Mutual

From:

Karl Guidry

713-676-1460

Fax:

512-224-3889

Pages: 2 Pages to follow

Attn:

Karen Crouse

Date:

January 14, 2009

See attached requested documentation regarding our employee Joey Sutter

Karl Guidry CES Environmental Services, Inc. HSE Manager 4904 Griggs Rd Houston, Texas 777021

713-676-1460 713-676-1676 Fax kguidry@cesenvironmental.com ****** DATE JAN-14-2009 **** TIME 12:47 *******

DATE/TIME

= JAN-13-2009 15:17

JOURNAL No.

= 191

COMM. RESULT = 634

PAGE(S)

= 000/008

DURATION

= 00:00:00

FILE No.

= 521

MODE

= MEMORY TRANSMISSION

DESTINATION

= 13613870794

RECEIVED ID

RESOLUTION

-CES Environmental Service-

***** DP-3010 **************** -

713 676 1676- *******

Send to workers' compensation carrier:

Texas Mutual 713-316-2191

(Name and fax number of carrier)



| CLAIM# | |
|-------------------|--|
| CARRIER'S CLAIM # | |

| | Initial | □ Amended |
|---|---------|-----------|
| _ | шиас | |

EMPLOYER'S WAGE STATEMENT

The Texas Workers' Compensation Act and Workers' Compensation rules require an employer to provide an Employer's Wage Statement to its workers' compensation insurance carrier (carrier) and the claimant or the claimant's representative, if any. The purpose of the form is to provide the employee's wage information to the carrier for calculating the employee's Average Weekly Wage (AWW) to establish benefits due to the employee or a beneficiary.

The AWW is based on the wages the employee earned in the 13 weeks immediately preceding the date of injury (or the wage a similar employee earned if the employee did not work the full 13-week period). "Wages" include all forms of remuneration payable to an employee for personal services, including fringe benefits. To simplify filing, employers may file wages in a monthly, biweekly, or weekly manner as discussed below.

NOTE - An employer who fails without good cause to timely file a complete wage statement as required by the Texas Workers' Compensation Act, Texas Labor Code, Section 408.063(c) and Worker's Compensation Rule 120.4 may be assessed an administrative penalty not to exceed \$500.00 for an initial offense and not to exceed \$10,000.00 for a repeated administrative violation.

The employer shall timely file a complete wage statement in the form and manner prescribed by the Division.

- (1) The wage statement shall be filed ("filed" means received) with the carrier, the claimant, and the claimant's representative (if any) within 30 days of the earliest of:
 - (A) the employee's eighth day of disability;
 - (B) the date the employer is notified that the employee is entitled to income benefits;
 - (C) the date of the employee's death as a result of a compensable injury.
- (2) The wage statement shall also be filed with the Division within seven days of receiving a request from the Division (Only When Requested).
- (3) A subsequent wage statement shall be filed with the carrier, employee, and the employee's representative (if any) within seven days if any information contained on the previous wage statement changes (such as if the employer discontinues providing a nonpecuniary wage that was initially continued after the date of injury).

| | | | All applicable DW | C ruies can be tound | at www.tdi.state.tx.us |
|---|--|---|---|--|---|
| EMPLOYEE A | ND EMPLOYER INFO | RMATION | i | | |
| Employee's Name (L | | <u></u> | Employer's Business Nar | ne: | |
| Sutter, Joey | · | | CES Environn | nental Service | es, In |
| Employee's Mailing / | Address (Street or P.O. Box): | | Employer's Mailing Addre | ss (Street or P.O. Box) |): |
| (b) (4) | | | 4904 Griggs Re | | |
| Citv | State: | ZIP Code: | City: | State: | ZIP Code: |
| (b) (4) | | | Houston | TX | 77021 |
| Social Security Numb | uer (last four digils). | | Federal Tax I.D. Number: | | |
| (b) (4) | | | 76-0592985 | | : |
| Date of Hire: | Date of Inju | ry: | Name and Phone # of Pe | rson Providing Wage (i | nformation: |
| (b) (4) | 12/18/ | 08 | Karl Guidry | | |
| ☐ The employee r ☐ without restr ☐ with restrictic week/month (cir | ons and is earning wages of | and is working: \$per Supplemental Report of | complies with the Texas and the listed wages incl (earned in) the 13 weeks and I understand that | Workers' Compensati ude all pecuniary and i prior to the date of inju- making a mistepres | nt is complete, accurate, and on Act and applicable rules, nonpecuniary wages paid for ury (as described on page 2) sentation about a workers fines and/or imprisonment. Date: 1-19-09 |
| EMPLOYMENT | STATUS AT TIME O | F INJURY (Check A | (II That Apply) | 1 | |
| least 30 hours per vicomparable to other and/or other employ-vicinity who are consi | oyee who regularly works at week and whose schedule is employees of the company es in the same business or dered full-time. The seasonal or cyclical or cyclical works as regular course of the seasonal or cyclical works as the seasonal or cyclical works as the seasonal or cyclical the seasonal the seasonal the seasonal or cyclical the seasonal the seaso | employee whose work period preceding the inju worked part-time during t Part-time: Not Regi employee whose work | ular Course of Conduct: history for the 12-month ry shows part-time and full | and not emancipat action who is also student. Student: emplo | te less than 18 years of age led by marriage or judicial an apprentice, trainee or leave enrolled in a course of college or other institute of technical training. |

SAME OR SIMILAR EMPLOYEE?

nature and that does not continue throughout the

The wage information on this form is for:

☑ The Injured Employee OR □ A Similar Employee (NOTE - If requested by the Division, the employer shall identify the similar employee whose wages were provided.)

If the employee was not employed for 13 continuous weeks before the date of injury, report the wages of an employee who has training, experience, skills & wages comparable to the injured employee AND who performs services/tasks comparable in nature and in number of hours. If no similar employee exists, report the limited available wages earned by the injured employee prior to the injury.

NOTE TO INJURED EMPLOYEE - If you were injured on or after 7/1/02, and had employment with more than one employer on the date of injury, you can provide your insurance carrier with wage information from your other employment for the carrier to include in your AWW and this may affect your benefits. Contact your carrier for additional information or call the Division at (800) 252-7031. You can also read rule 122.5 at www.tdi.state.tx.us.

■ Apprentice: employee who is learning a skilled

trade or art by practical experience under the

direction of a skilled crafts person or artisan.

DIVISION OF WORKERS' COMPENSATION

☐ Trainee: employee undergoing systematic

instruction and practice in some art, trade or

profession with a view towards proficiency in it.

vear.

Nonpecuniary Wages include all wages paid to the employee in a form other than money. These include, but are not limited to, the

- The employer shall report all wages earned in the 13 weeks immediately preceding the date of injury. If the employee is paid on a monthly or semi-monthly basis, the employer may provide wages for the 3 months preceding the date of injury. Monthly wages may also be converted to weekly wages by dividing the gross monthly amount by 4.34821. If the employee is paid on a biweekly basis, the employer may provide the wages for the 14 weeks preceding the date of injury. When setting the periods to report, the employer may adjust the reporting period backward slightly (up to six days) to line up the reporting timeframes with the employer's natural pay cycle. However, the employer shall not report wages earned on or after the date of injury.
- If reporting weekly earnings, use all 13 Period Columns below. If reporting 3 months of earnings, either convert the wages to weekly earnings or use the first 3 Period Columns. In all cases, indicate the dates that each period covers.

| PECUNIARY WAGE I | NFORMA | ATION | | hourly, we commissio commissio use of the | ekly, biweel ons. Earnin ons) need to employee's | kly, monthly gs are repo be prorated equipment | r, etc. wages inted in the I. Pecuniary | s; salary; tip periods the wages don helpers or | s/gratuities; y are earne t include pa to reimburs | piecework of d, NOT whe yments mad e for travel of | compensation they are e by an emperor expenses. | on; monetar paid and so ployer to rein Consider as | y allowance: ome (such a mburse the e earnings am | re not limited to: s; bonuses; and as bonuses and employee for the counts from paid not used. |
|---|---------|----------|----------|--|---|---|---|--|---|---|---|---|--|---|
| PERIOD # (Week #, Month #, or Bi-Week #) | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | |
| FROM DATE: | 9/21/08 | 9/28/08 | 10/05/08 | 10/12/08 | 10/19/08 | 10/26/08 | 11/02/08 | 11/09/08 | 11/16/08 | 11/23/08 | 11/30/08 | 12/07/08 | 12/14/08 | |
| TO DATE: | 9/27/08 | 10/04/08 | 10/11/08 | 10/18/08 | 10/25/08 | 11/01/08 | 11/08/08 | 11/15/08 | 11/22/08 | 11/29/08 | 12/06/8 | 12/13/08 | 12/20/08 | TOTALS |
| # HOURS WORKED: | 80:13 | 73:01 | 55. | 46:05 | 46:11 | 68:35 | 39:13 | 71:23 | 45:26 | 46:28 | 69:28 | 71:22 | 41:18 | 752:23 |
| GROSS WAGES EARNED: | (b) (4) | | | | | | | | | | | | | |

| Nonpecuniary Wage Type | Provide | loyer ed Prior jury? | Spe | cify Valu | ue Or An | nount Ea | | | | eriod For as used a | | enefit Pro | vided P | rior To In | jury | Conti | nployer nue To /ide? | Date Benefit Suspended (if suspended) |
|---------------------------|---------|----------------------------|-----|-----------|----------|----------|---|---|---|------------------------|---|------------|---------|------------|------|-------|----------------------------|---|
| | YES | NO | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | YES | NO | 1 |
| Health Insurance | | | | | | | | | | | | | | | | | | |
| Laundry/ Cleaning | | | | | | | | | | | | | | | | | | |
| Clothing/ Uniforms | - | | | | | | | | : | | | | | | | | | |
| Lodging/ Housing/ | | | | | | | | | | | | | | | | | | |
| Food/ Meals | | | | | | | | | | : | | | | | | | | |
| Vehicle/ Fuel | | | | | | | | | | | | | | | | | | |
| Other | | | | | | | | | | | | | | | | | | |



EPAHO042001465

| 12-32-08 | 19. | - 22- | 08 |
|----------|-----|-------|----|
|----------|-----|-------|----|

To: Kimi SCARPA

From: KARI Guidry

TAX # 281-286-6352

Pages & follow: 3

Please find OS ha 300, 30A + 301 Forms to Tollow.

Add'I info requested includes:

FeD Tax ID# 26-3588960

of Employees = 15

Contact info: Keld Anderson, Fraility Manager 630-212-0437

EPAHO042001467

OSHA's Form 300 Log of Work-Related Injuries and Illnesses

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

City

Port Arthur

Year 2008 Occupational Safety and Health Administration

U.S. Department of Labor

Form approved OMB no. 1218-0176

State Texas

You must record information about every work-related injury or illness that involves loss of consciousness, restricted work activity or job transfer, days away from work, or medical treatment beyond first aid. You must also record significant work-related injuries and illnesses that are diagnosed by a physician or licensed health care professional. You must also record work-related injuries and illnesses that are diagnosed by a physician or licensed health care professional. You must also record work-related injuries and illnesses that are diagnosed by a physician or licensed health care professional. You must also record work-related injuries and illnesses that are diagnosed by a physician or licensed health care professional. You must also record work-related injuries and illnesses that are diagnosed by a physician or licensed health care professional. You must also record work-related injuries and illnesses that are diagnosed by a physician or licensed health care professional. You must also record work-related injuries and illnesses that are diagnosed by a physician or licensed health care professional. You must also record work-related injuries and illnesses that are diagnosed by a physician or licensed health care professional. any of the specific recording criteria listed in 29 CFR 1904.8 through 1904.12. Feel free to use two lines for a single case if you need to. You must complete an injury and illness incident report (OSHA Form 301) or equivalent form for each injury or illness recorded on this form. If you're not sure whether a case is recordable, call your local OSHA office for help.

Establishment name Port Arthur Chemical & Environ Services, LLC

| A) ise lo. | (B) Employee's Name | (C) Job Title (e.g., Welder) | (D) Date of injury or onset of | (E) Where the event occurred (e.g. Loading dock north end) | (F) Describe injury or illness, parts of body affected, and object/substance that directly injured or made person ill (e.g. Second degree burns on right forearm from | serious | result for eac | | Y the most | the injured o | | Check the type of illr | ness: | | | |
|------------------|-----------------------------------|--|--------------------------------|---|---|--|----------------|--------------------------------|------------------------|--|-----------------------------|------------------------|---------------|--------------------------|--------------|--------------------------|
| | | | illness (mo./day) | | acetylene torch) | Death | | Job transfer or restriction | other recordable cases | On job transfer or restriction (days) | Away from work (days) | injury (| Skin Disorder | Respiratory Condition | Poisoning | – a All other illness |
| 1 10 | ey W. Sutter | Technician | 12/18/08 | PACES Complex | Death (waiting for report) | (G) | (H) | (I) | (J) | (K) | (L) | (1) | (2) | (3) | (4) | 1 (|
| 1130 | ey vv. Suller | rectinician | 12/10/00 | PACES Complex | Death (waiting for report) | × | | | <u> </u> | | 1 | | | | | H |
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| L | | l | <u> </u> | <u></u> | Page totals | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 十 |
| w the i | instruction, search and gather th | e data needed, and co | mplete and revi | 14 minutes per response, including time to few the collection of information. Persons mently valid CMB control number. If you | | the Su | immary pag | ge (Form 30 | 10A) before yo | ou post it. | • | Vinjul | Skin Disorder | Respiratory Condition | Paisoning | |

Office of Statistics, Room N-3644, 200 Constitution Ave, NW, Washington, DC 20210. Do not send the completed forms to

EPAHO042001468

OSHA's Form 300A Summary of Work-Related Injuries and Illnesses



U.S. Department of Labor

Occupational Safety and Health Administration

Form approved OMB no. 1218-0176

| All establishments covered by Part 1904 must complete this Summary page, even if no injuries or |
|--|
| Market and Addition of the control o |

'Using the Log, count the individual entries you made for each category. Then write the totals below, making sure you've added the entries from every page of the log. If you had no cases write "O."

Employees former employees, and their representatives have the right to review the OSHA Form 300 in its entirety. They also have limited access to the OSHA Form 301 or its equivalent. See 29 CFR 1904.35, in OSHA's Record

| Total number of deaths | Total number of cases with days away from work 0 | Total number of cases with job transfer or restriction | Total number of other recordable cases |
|--|--|--|---|
| (G) | (H) | (1) | (J) |
| Number of Days | | | |
| Total number of | | Total number of days | |
| days of job transfer or restriction | | away from work | |
| 0 | _ | 0 | _ |
| (K) | | (L) | |
| John a hypersoneth brough | ypes | A STATE OF THE STA | THE COLUMN TWO IS NOT |
| Injury and Illness T | 3 T. APARTHER STOP: 15 - 70 | | |
| Total number of | ar in the second | | |
| Total number of (M) (1) Injury | 0 | (4) Poisoning | 0 |
| Total number of (M) | 0 | (4) Poisoning (5) All other illnesses | 0 0 |

Post this Summary page from February 1 to April 30 of the year following the year covered by the form

Public reporting burden for this collection of information is estimated to average 50 minutes per response, including time to review the instruction, search and gather the data needed, and complete and review the collection of information. Persons are not required to respond to the collection of information unless it displays a currently valid OMB control number. If you have any comments about these estimates or any aspects of this data collection, contact: US
Denartment of Lahor, OSHA Office of Statistics. Room N-3844 200 Constitution Ave. NW. Washington DC 20210. Do not send the completed forms to this

| Your estab | lishment name | Port Arthur Chem | ical Environon | mental Serv | ices, LLC | _ |
|--|--|---|-------------------|--------------|----------------------|----|
| Street 242 | 20 South Gulfwa | y Drive | | | | |
| City <u>Po</u> | rl Arthur | | State | TX | Zip776 | 40 |
| , | scription (e.g., M mufcaturing facili | lanufacture of moto | r truck trailers) | ı | | _ |
| Stendard li | ndustrial Classifi | cation (SIC), if know | vn (e.g., SIC 3 | 715) | | |
| Employr | nent informa | tion | | | | |
| Annual ave | erage number of | employees | 15 | | | |
| | | | | | | |
| Total hours | s worked by all e | mpløyees last year | | | | |
| Total hours | • | mployees last year | | | | |
| Sign hei | ·e | mployees last year cument may result | | | | |
| Sign her Knowingly I certify tha | 'e falsifying this do | cument may result | in a fine. | est of my kn | owledge the | |
| Sign her Knowingly I certify tha | falsifying this do tt I have examine true, accurate, a | cument may result | in a fine. | est of my kn | owledge the Title | |

EPAHO042001469

OSHA's Form 301 Injuries and Illnesses Incident Report

Date

ſ∏Yes

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

18) If the employee died, when did death occur? Date of death



Occupational Safety and Health Administration

Form approved OMB no. 1218-0176

12/18/2008

Information about the employee Information about the case This Injury and Illness Incident Report is one of the 1) Full Name Sutter Joey W Case number from the Log 1 (Transfer the case number from the Log after you record the case.) first forms you must fill out when a recordable work-11) Date of injury or illness related injury or illness has occurred. Together with the Log of Work-Related injuries and Illnesses and State TX Zip 75110 12) Time employee began work AM/PM the accompanying Summary, these forms help the employer and OSHA develop a picture of the extent 7/4/1972 AM/PM Check if time cannot be determined 3) Date of birth 13) Time of event and severity of work-related incidents. Within 7 calendar days after you receive 4) Date hired 8/25/2008 14) What was the employee doing just before the incident occurred? Describe the activity, as well as the tools, equipment or material the employee was using. Be specific. Examples: "climbing a ladder information that a recordable work-related injury or 5) X Male while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key-entry." illness has occurred, you must fill out this form or ☐ Female an equivalent. Some state workers' compensation, insurance, or other reports may be acceptable Information about the physician or other health care substitutes. To be considered an equivalent form. professional any substitute must contain all the information 15) What happened? Tell us how the injury occurred. Examples: "When ladder slipped on wet floor, 6) Name of physician or other health care professional According to Public Law 91-596 and 29 CFR worker fell 20 feet"; "Worker was spayed with chlorine when gasket broke during replacement"; 1904, OSHA's recordkeeping rule, you must keep "Worker developed soreness in wrist over time." this form on file for 5 years following the year to which it pertains 7) If treatment was given away from the worksite, where was it given? If you need additional copies of this form, you may photocopy and use as many as you need. 16) What was the injury or illness? Tell us the part of the body that was affected and how it was affected; be more specific than "hurt", "pain", or "sore." Examples; "strained back"; "chemical burn, hand": "carpal tunnel syndrome." ____State ___Zip 8) Was employee treated in an emergency room? Completed by 17) What object or substance directly harmed the employee? Examples: "concrete floor": "chlorine": ∏No "radial arm saw." If this question does not apply to the incident, leave it blank. 9) Was employee hospitalized overnight as an in-patient?

Public reporting burden for this collection of information is estimated to average 22 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Persons are not required to respond to the collection of information unless it displays a current valid OMB control number. If you have any comments about this estimate or any other aspects of this data collection, including suggestions for reducing this burden, contact. US Department of Labor, OSHA Office of Statistics, Room N-3844, 200 Constitution Ave, NW, Washington, DC 20210. Do not send the completed forms to this office.

Karl Guidry

From:

Krissy Reese

Sent:

Friday, December 19, 2008 3:29 PM

To:

Knighton, Kelly - OSHA

Cc:

Karl Guidry; Figueroa, Joann - OSHA; Briggs, Mark - OSHA

Subject: RE: Port Arthur CES Environmental Services

Kelly,

Per Karl's request, all the information you have requested will be faxed to you from our Houston office.

From: Knighton, Kelly - OSHA [mailto:Knighton.Kelly@dol.gov]

Sent: Friday, December 19, 2008 2:45 PM

To: Krissy Reese

Cc: Karl Guidry; Figueroa, Joann - OSHA; Briggs, Mark - OSHA

Subject: RE: Port Arthur CES Environmental Services

Hi Krissy,

Thanks for sending the information. I also need the next of kin, name and address as well as the shipping manifest for the truck.

Thanks.

Kelly Knighton Assistant Area Director

From: Krissy Reese [mailto:kreese@cesenvironmental.com]

Sent: Friday, December 19, 2008 12:40 PM

To: Knighton, Kelly - OSHA

Cc: Karl Guidry

Subject: Port Arthur CES Environmental Services

ÉxonMobil

MATERIAL SAFETY DATA BULLETIN

PAGE 1 OF 8

MCP 1397

1. PRODUCT AND COMPANY IDENTIFICATION

PRODUCT NAME: MCP 1397 SUPPLIER: EXXONMOBIL CHEMICAL COMPANY SYNTHETICS DIVISION 2195 ROUTE 27 EDISON, NJ 08818

24 - Hour Emergency (call collect): 609-737-4411 Product and MSDS Information: 732-321-6048 CHEMITREC: 800-424-9300

732-321-6048 202-483-7616

2. COMPOSITION/INFORMATION ON INGREDIENTS

CHEMICAL NAMES AND SYNONYMS: SULFURIZED ISOBUTYLENE

INGREDIENTS CONSIDERED HAZARDOUS TO HEALTH:

This product is not formulated to contain ingredients which have exposure limits established by U.S. agencies. It is not hazardous to health as defined by the European Union Dangerous Substances/Preparations Directives. See Section 15 for a regulatory analysis of the ingredients.

OTHER POTENTIALLY BAZARDOUS INGREDIENTS:

Wts Substance Name SULFURIZED ALKENE 100

See Section 15 for European Label Information.

See Section 3 for exposure limits (if applicable).

MATERIAL SAFETY DATA BULLETIN

20APR1999

MCP 1397

PAGE 2 OF 8

3. HAZARDS IDENTIFICATION

William Contraction to accompanies of the property of the contraction

US OSHA HAZARD COMMUNICATION STANDARD: Product assessed in accordance with OSHA 29 CFR 1910.1200 and determined to be hazardous. EFFECTS OF OVEREXPOSURE: Respiratory irritation, dizziness, nausea loss of consciousness. Prolonged repeated skin contact with low viscosity materials may defat the skin resulting in possible irritation and dermatitis.

EMERGENCY RESPONSE DATA: Amber Liquid. Material is combustible. Exposure to fire can generate highly toxic fumes. DOT ERG No. : 128 . SEC: 2

4. FIRST AID MEASURES

EYE CONTACT: Flush thoroughly with water. If irritation occurs, call

a physician. SKIN CONTACT: Wash contact areas with somp and water. Remove contaminated clothing. Launder contaminated clothing before

INMALATION: Remove from further exposure. If respiratory irritation, dizziness, nausea, or unconsciousness occurs, seek immediate medical assistance and call a physician. If breathing has stopped, use mouth to mouth resuscitation.

INGESTION: Do not induce vomiting. Get medical assistance.
NOTE TO PHYSICIANS: Material if aspirated into the lungs may cause chemical pneumonitis. Treat appropriately.

5. FIRE-FIGHTING MEASURES

EXTINGUISHING MEDIA: Carbon dioxide, foam, dry chemical and water fog-SPECIAL FIRE FIGHTING PROCEDURES: Use water to keep fire exposed containers cool. If a leak or spill has not ignited, use water spray to disperse the vapors and to protect personnel attempting to stop leak. Mater spray may be used to flush spills away from exposures. Prevent runoff from fire control or dilution from

exposures. Prevent functi from the control of dilution from entering streams, sewers, or drinking water supply.

SPECIAL PROTECTIVE EQUIPMENT: For fires in enclosed areas, fire fighters must use self-contained broathing apparatus.

UNUSUAL FIRE AND EXPLOSION HAZARDS: Material is combustible. Expos to fire can generate highly toxic funes. Flash Point C(F):

\$1(178) (ASTM D-93). Flammable limits - LEL: NE, UEL: NE.

NFPA HAZARD ID: Health: 2, Flammability: 2, Reactivity: 0 RAZARDOUS DECOMPOSITION PRODUCTS: Carbon monoxide. Sulfur exides.

MATERIAL SAFETY DATA BULLETIN

20APRI 999

MCF 1397

PAGE B OF 8

6. ACCIDENTAL RELEASE MEASURES

NOTIFICATION PROCEDURES: Report spills as required to appropriate authorities. U. S. Coast Guard regulations require immediate reporting of spills that could reach any waterway including intermittent dry creeks. Report spill to Coast Guard tell free number (800) 424-8802. In case of accident or road spill notify

CHEMTREC (800) 424-9300. PROCEDURES IF MATERIAL IS RELEASED OR SPILLED: Eliminate all ignition sources. Adoorb on fire retardant treated sandust, distomaceous earth, etc. Shovel up with spark-resistant shovel and remove to appropriate wasts disposal facility in accordance with current

applicable laws and regulations.

ENVIRONMENTAL PRECAUTIONS: Prevent spills from entering storm sewers or drains and contact with soil. PERSONAL PRECAUTIONS: See Section 6

7. HANDLING AND STORAGE

HANDLING: Use in well ventilated area away from all ignition sources. Avoid sparking conditions. Ground and bond all transfer equipment.

STORAGE: Store in a cool area away from all ignition sources. Store in a cool area.

8. EXPOSURE CONTROLS/PERSONAL PROTECTION

VENTILATION: Use local exhaust over heating operations. Use in well ventilated area. Ventilation desirable and equipment should be

explosion proof.
RESPIRATORY PROTECTION: Use appropriate respiratory protective equipment during heating operations.

EYE PROTECTION: Normal industrial eye protection practices should be

SKIN PROTECTION: If prolonged or repeated skin contact is likely, impervious gloves should be worn. Good personal hygiene practices should always be followed.

EXPOSURE LIMITS: This product does not contain any components which have recognized exposure limits.

9. PHYSICAL AND CHEMICAL PROPERTIES

Typical physical properties are given below. Consult Product Data Sheet for specific details.

APPEARANCE: Liquid COLOR: Amber ODOR: Mercaptan ODOR THRESHOLD-pom: NE AM: Hq

(Section continued next page)

ExonNobii

MATERIAL SAFETY DATA BULLETIN

20APR1999

MCP 1397

PAGE 4 OF S

BOILING BOINI C(F): NE

MELTING BOINT C(F): NA

FLASH BOINT C(F): 81(178) (RSTM D-93)

FLAMMABILITY: NE

AUTO FLAMMABILITY: NE

EXPLOSIVE PROPERTIES: NA

OXIDIZING EROPERTIES: NA

VAPOR PRESSURE-MMH9 20 C: NE

VAPOR DENSITY: NE

EVAPORATION RATE: NE

RELATIVE DENSITY. 15/4 C: 1.03

SOLUBILITY IN WATER: Negligible

PARTITION COEFFICIENT: NE

VISCOSITY AT 40 C, CSt: 5.3

VISCOSITY AT 40 C, CSt: 1.7

POUR FOINT C(F): < -64(-83)

FREEZING POINT C(F): NE

VOLATILE ORGANIC COMPOUND: NE

NA=NOT APPLICABLE NE=NOT ESTABLISHED D=DECOMPOSES

FOR FURTHER TECHNICAL INFORMATION, CONTACT YOUR MARKETING REPRESENTATIVE

10. STABILITY AND REACTIVITY

STABILITY (THERMAL, LIGHT, ETC.): Stable.
CONDITIONS TO AVOID: Heat, sparks, flame and build up of static electricity.
INCOMPATIBILITY (MATERIALS TO AVOID): Strong oxidizers.
HAZARDOUS DECCHPOSITION PRODUCTS: Carbon monoxide. Sulfur oxides.
HAZARDOUS POLYMERIZATION: Will not occur.

11. TOXICOLOGICAL DATA

ORAL TOXICITY (RATS): Practically non-toxic.

DERMAL TOXICITY (RABBITS): Practically non-toxic (LD50: greater than 2000 mg/kg). ——Based on testing of similar products and/or the components.

INHALATION TOXICITY (RATS): Practically non-toxic (LC50: greater than 5 mg/l). ——Based on testing of similar products and/or the components.

EYE IRRITATION (RABBITS): Practically non-irritating. Eye irritation scores: 6.0 at 24 hours, 3.3 at 48 hours, 2.3 at 72 hours

SKIN IRRITATION (RABBITS): Practically non-irritating. Primary irritation score: 0.3/3

OTHER ACUTE TOXICITY DATA: ***DOT skin corrosivity (4 hours):

Negative ***

---GENETIC TOXICOLOGY (SUMMARY) --
***Mouse Lymphoma (L5179Y/TK+/-) Assay: Positive. ***Negative Ames Test.

MATERIAL SAFETY DATA BULLETIN

Z0APR1999

MCP 1397

PAGE 5 OF 8

12. ECOLOGICAL INFORMATION

ENVIRONMENTAL FATE AND EFFECTS: After 28 days, 3.38 of this material was converted to CO2 in the OECD 301E (Modified Sturm) test.

13. DISPOSAL CONSIDERATIONS

WASTE DISPOSAL: Product is suitable for burning in an enclosed, controlled burner for fuel value or disposal by supervised incineration. Such burning may be limited pursuant to the Resource Conservation and Recovery Act. In addition, the product is suitable for processing by an approved recycling facility or can be disposed of at an appropriate government waste disposal facility. Use of these methods is subject to user compliance Use of these methods is subject to user compliance facility. with applicable laws and regulations and consideration of product characteristics at time of disposal.

RCRA INFORMATION: The unused product, in our opinion, is not product, in the three product, in our opinion, is not specifically listed by the EPA as a hazardous waste (40 CFR, Part 261D), nor is it formulated to contain materials which are listed hazardous wastes. It does not exhibit the hazardous characteristics of ignitability, corresivity, or reactivity and is not formulated with contaminants as determined by the Toxicity Characteristic Leaching Procedure (TCLP). Rowever, used product may be regulated.

14. TRANSPORT INFORMATION

USA DOT:

STCC:

SHIPPING NAME:

Combustible Liquid, n.o.s. (contains SULFURIZED ISOBUTYLENE)

COMBUSTIBLE LIQUID

ID NUMBER: NA1993 ERG NUMBER:

128 PG III

PACKING GROUP:

DANGEROUS WHEN WET:

HAZARD CLASS & DIV:

POISON:

ИD

LABEL(s):

NA

PLACARD(s):

Combustible

PRODUCT RQ:

MARPOL III STATUS:

In accordance with 49 CFR 173,150(f)(2), non-bolk quantities of this material (<219 gallons per container) may be shipped as non regulated - for USA domestic shipments.

RID/ADR: NOT REGULATED BY RID/ADR.

INO: NOT REGULATED BY INO.

(Section continued next page)

MATERIAL SAFETY DATA BULLETIN

20APR1999

MCP 1397

PAGE 5 OF 8

TATA: NOT REGULATED BY TATA.

15. REGULATORY INFORMATION

Governmental Inventory Status: All components comply with TSCA, EINECS/ELINCS, AICS, METI, and DSL.

EU Labeling:

Symbol: Not applicable.

Risk Phrase(s): Not applicable.

Safety Phrase(s): S24-62.

Avoid contact with skin. If swallowed, do not induce vomiting: seek medical advice immediately and show this container or label.

Contains: Sulfurized Isobutylene.

U.S. Superfund Amendments and Reauthorization Act (SARA) Title III: This product contains no "EXTREMELY HAZARDOUS SUBSTANCES".

SARA (311/312) REPORTABLE HAZARD CATEGORIES: FIRE CHRONIC

This product contains no chemicals subject to the supplier notification requirements of SARA (313) toxic release program.

The following product ingredients are cited on the lists below:
CHEMICAL NAME CAS NUMBER LIST CITATIONS

*** NO REPORTABLE INGREDIENTS ***

Code key: CARC=Carcinogen; SUS=Suspected Carcinogen; REPRO=Reproductive

MATERIAL SAFETY DATA BULLETIN

20APR1999

MCP 1397

PAGE 7 OF 8

16. OTHER INFORMATION

Precautionary Label Text:

CONTAINS SULFURIZED HYDROCARBONS

CAUTION!

COMBUSTIBLE LIQUID AND VAPOR. MAY CAUSE MOSE, THROAT AND LUNG IRRITATION, DIZZINESS, NAUSEA, LOSS OF CONSCIOUSNESS. LOW VISCOSITY MATERIAL-IF SWALLOWED, MAY BE ASPIRATED AND CAN CAUSE SERIOUS OR FATAL LUNG DAMAGE.

PROLONGED, REPEATED SKIN CONTACT MAY CAUSE IRRITATION.

Keep away from heat and flame. Avoid contact with skin or clothing. Avoid breathing vapor. Keep container closed. Use with adequate ventilation.

FIRST AID: If inhaled, remove to fresh air. If not breathing, give artificial respiration, preferably mouth-to-mouth. If breathing is difficult, give oxygen. Call a physician immediately. In case of contact, wash skin with soap and water. Remove containnated clothing. Call a physician if irritation persists. Wash clothing before reuse. If swallowed, seek immediate medical attention. Do not induce vomiting. Only induce vomiting at the instruction of a physician.

For industrial use only. Not intended or suitable for use in or around a household or dwelling.

Empty container may contain product residue, including flammable or explosive vapors. Do not cut, puncture, or weld on or near container. All label warnings and precautions must be observed until container has been thoroughly cleaned or destroyed.

Refer to product Material Safety Date Bulletin for further safety and health information.

USE: EXTREME PRESSURE ADDITIVE

NOTE: PRODUCTS OF EXXON MOBIL CORPORATION AND ITS AFFILIATED COMPANIES ARE NOT FORMULATED TO CONTAIN PCBS.

ingredient

cas number

1-PROPENE, 2-METHYL-, SULFURIZED

68511~50-2

For Internal Use Only: MHC: 0 1° 0° 0 1, MPPEC: C, TRN: 6013973-00, REQ: CHEMICAL PRODUCTS, SAFE USE: C

EHS Approval Date: 20APR1999

(Section continued next page)



Label[®]laster® Chicago, IL 60646



Patriot Security EOC Proudest Employee Owned Company In TEXAS!

INCIDENT REPORT

| DATE: | TIME, AM |
|--|--|
| 19 - 185 < 0 \$ POST: Ex. Beaumont Enterprise | LOCATION: Ex. 2 nd Ploor |
| SECURITY OFFICERS NAME (PRINT): | POLICE DEPARTMENT: Ex. Beaumont PD. |
| LAUREL L. APCALISON | |
| WITNESS: | AMBULANCE Ex. Priority One |
| Witness: | FIRE DEPARTMENT: Ex. Beaumont FD Fold Briller |

PRINT INCIDENT DETAILS IN ALL CAPITAL LETTERS COMPLETE INCIDENT DRAWING ON BACK

| DY BPPRON 3:03 I WEARD B CALL FOR MIELP. PERSON |
|---|
| CALLING FOR SIGLA WAS BUZI MOCH CES EMPLOYEE ON TOP |
| OF TRAILER TONK \$ 267 WITH JORY SUTTEN CAS EMPLOYER |
| JOBY SUTTEN WAS PASSED-OUT ONTON OF JONK |
| I RAN TO TAUK FROM SCALE BULDING CALLING ON |
| KADIO FOR HELP. BROD WOOD CES EMPLOYER BUSEASES |
| ANSWERED CALL FOR SIKLA BURIUNG AT SITE WITH-IN |
| A MIN. OFFICE MANAGAN K. REESE COLLED 911 DE |
| At APPROX - 9:04 PM - AT APROLOG! 3:20 PORT |
| ANTHUR F/D ARRIVED. :5/5 TAMES ON SITE TO |
| ASSIST, CALLED OFFICE OF REP-RT. PROBLED. BT OPPROV |
| 9: 84 STAT CARE AMBUCAUCE ARRIVED ON SITE. |
| PORT ANTHUR FID AND CES EMPLOYEES HELP BRING |
| JOHN SUTTEN BEE TOP OF TANK 2:38 STAT CARLE |
| AMBULANCE LAST SITE WITH JOEN SUTTEN ON BOOKD |
| PLANT MANACOR KAL MADERSON OF OPERATION SUPER DISOR |
| BRIAN WEATHERS LATIFIED BY APPROX 2:15 AS THEY DETAINED |
| ENON LUNCH |
| - |

Security Officer's Signature:

_Employee # <u>/006</u>

Confidential and Proprietary Patriot Security EOC

Proudest Employee Owned Company In TEXAS!







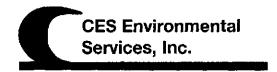
Tom Gillam, III

JUSTICE OF THE PEACE

PRECINCIEIGHT JEFFERSON COUNTY, PORT ARTHUR TEXAS

SUB-COURTHOUSE 525 LAKESHORE DRIVE PORT ARTHUR, TEXAS 77640

OFC: (409) 983-8330 FAX: (409) 749-3670



4904 Griggs Road Houston, TX 77021 Tel. (713) 676-1460 Fax. (713) 676-1676 www.cesenvironmental.com

Fax

| To: | Judge Tom | From: | Keld Andersen | | | | | |
|--------|---|------------------|----------------|------------------|--|--|--|--|
| Fax: | 409-749-3670 | Pages: | 13 | | | | | |
| Phone | > : | Date: | 12/29/08 | | | | | |
| Re: | Joey Sutter's Death | ¢c: | | | | | | |
| 🗆 Urg | ent 🗀 For Review | ☐ Please Comment | □ Please Reply | ☐ Please Recycle | | | | |
| • Com | nments: | <u></u> | | | | | | |
| | Attached are the documents we provided OSHA for the incident that happened a few weeks ago. If there is anything else I can assist you with please let me know. | | | | | | | |
| Thank | you, | | | | | | | |
| Keld A | ndersen | | | | | | | |



4904 Griggs Road Houston, TX 77021 Tel. (713) 676-1460 Fax. (713) 676-1676 www.cesenvironmental.com

Fax

| To: | Ke | lli Knight | From: | Karl Guidry | | | | |
|-------|-----------|----------------------------------|-------|----------------|------------------|--|--|--|
| Fax: | 28 | 1-286-6352 | Pages | 12 | | | | |
| Phone | : | | Date: | 12/19/08 | | | | |
| Re: | Tra | iler #267 | cc: | | | | | |
| □ Urg | ent | nt ☐ For Review ☐ Please Comment | | ☐ Please Reply | ☐ Please Recycle | | | |
| • Com | Comments: | | | | | | | |

Attached are the bills of ladings for the last 11 loads of SIB received. The material inside of trailer #267 was the recovered oil from these loads.

EPAHO042001482

Ryan Thomas

From:

Keld Andersen

Sent:

Monday, December 29, 2008 11:28 AM

To:

Ryan Thomas

Cc:

Karl Guidry; Matt Bowman; Greg Bowman

Categories:

important

Ryan per our conversation, and pursuant to my being issued a subpeona for information re: Joey's passing, please fax to:

409 - 749 - 3670, attn. Judge Tom? re: Joey Sutter's death the following information that we already supplied OSAH,

1. his SSN



2. nature of material (composition) in subject trailer

3. origin of 2. above.

They would like this as soon as we can practicably provide it.

Thanks,

Keld

Port Arthur Chemical Environmental Services PO Box 218 Port Arthur Tx 77641-0218 kandersen@cesenvironmental.com 630-212-0437

CES Environmental Services, Inc.

Bill Of Lading #:

77085

| | | | | | ************************************** | | | | |
|--|--|---|--|--|--|---|--|--|--|
| Fold | ler ID : | | KMCO (KMCO - Croeby, TX) SIB Hazardous Wastewater | | | | | | |
| Orig | ginal – Sh | ipper | Provided | Short F | orm Straight Bill of Lading – Not Negotiable – De | omestic | | | |
| SH | IPPED F | RON | A : | | | | | | |
| | ICO, Inc | | | | 11a) PA-2804 | | | | |
| | 503 Ram | _ | | | 11b) | | | | |
| Crosby , TX 77532 11c) | | | | | | | | | |
| (28 | (1) 328-3 | 501 | | | 11c) | | | | |
| said of carry goods any till between For particular to 8th | tarrier (the wor to its uracsus) (s it is not of its me interested) sen shipper and syment. Charge pper or the "Bill | d camer place of (elf a cons n all or a l camer s to be b led to" pa | being understo delivery at said tract of carriage my of said proper or intermediary. | ed throughou destination, . It is makudi erly, that eve or the "Bille r written con | cept as noted (content and condition of packages unknown), marked, consign this as meaning any person or corporation authorized to be in possession of finits rouse, otherwise to deliver to another carrier on the rouse to said destiny a gyreed, as to each carrier of all or as to any said over all or any portion of a y service to be performed hereunder shall be subject to all the terms and cor dito" party are set forth in the governing contract with Shipper. No charges oth sent of Shipper. The extra copy of this Bill of Lading, furnished at the time of a | If the property under the contract) agrees to uston. This Bill of Lading is a receipt for isid route to destination, and as to each party iditions contained in the applicable contract ar than those contained therein may be billed | | | |
| | | | | IIO SOLETO: | CADDIED . | · . | | | |
| | NSIGNE 9. Environ | |) : ıtal Servi | cae In | CARRIER : c. CES Environmental Serv | icae Inc | | | |
| | 4 Griggs | | ilai Jeivi | ces, iii | 4904 Griggs Rd. | nces, mc. | | | |
| | uston . T | | 021 | | Houston , TX 77021 | • | | | |
| This is | s to certify that t | ine produ | ict stated below | | classified, described, packaged, marked and labeled and is in proper conditi If this Shipment moves between to ports by a carrier by water, the law requir | | | | |
| lt is "c | arrier's or ship | per's we | oht." | | | · | | | |
| | | | | | Highway Administration regulations at 49 CFR 330,54© implementing the intrinis the tendering party. | ermodel ৪০টি Certainer Act যে 1992 (s হল | | | |
| Haz | Contain | ler | Total | Unit | Description of Materials, Special Marks, an | d Exceptions | | | |
| | No. | Туре | Quantity | MAAOI | | | | | |
| Yes | 1 | T T | 2000 | , p | RQ, Corrosive, liquid, basic, inorganic (sodium h | ydroxide), 8, UN3266, PG II | | | |
| | | | 35900 | | | • | | | |
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| _ | · // | R | | **** | Cimphina | Deta | | | |
| Per | 1014 | peu | | | Signature : | Date : | | | |
| Carr | ior CES | S Env | /ironmen | tal Ser | vices, Inc. | | | | |
| | | | | · | | - 15 S. D. | | | |
| Per | :/\\ | المكاما | Wil | FOL | Signature : Labelloo | Date: <u>(→ → → → → → → → → → → → → → → → → → </u> | | | |
| Rec | eiving F | acili | y <u>:CES</u> | Enviro | mental Services, Inc. | | | | |
| Per | : Gc | d | $e[\infty]$ | | Signature : | Date: 12/1/08 | | | |
| White | e (Generator | Return | сору) (| Yellow | (Transporter Copy) Pink (Receiving Facility Copy) | Golden Rod (Generator 1st Copy) | | | |

CES Environmental Services, Inc.

Bill Of Lading #:

77086

| 医多点体 化硫化盐 化化二 | "我看了,""一点,""一点的,这个经历的数据的,这一多样的数 | | |
|---------------|---|--|--|
| Folder ID : | KMCO (KMCO - Croeby, TX) SIB Hazardous Wastewater | | |
| | | ght Bill of Lading – Not Negotiable – Domestic | |
| SHIPPED F | ROM: | | |
| KMCO, Inc. | | 11a) PA-2804 | |
| 16503 Ram: | sey Rd. | 11b) | |
| Crosby , TX | 77532 | 11c) | |

The properly described below, in superers good order, to cept as noted (content and condition of packages unknown), marked, consigned, and destined as indicated below, which said carrier (the word carrier being understood throughout this as meaning any person or corporation authorized to be in possession of the properly under the contract) agrees to carry to its unusual place of delivery at said destination, if on its route, otherwise to deliver to another carrier on the route to said destination. This bill of Lading is a receipt for goods; it is not of itself a contract of carriage, it is mutually agreed, as to each carrier of all or as to any portion of said route to destination, and as to each party at any time interested in all or any of said property, that every service to be performed hereunder shall be subject to all the terms and conditions contained in the applicable contract between shipper and carrier or intermediany.

For payment: Charges to be billed to Shipper or the "Billed to" party are set forth in the governing contract with Shipper. No charges other than those contained therein may be billed to Shipper or the "Billed to" party without prior written consent of Shipper. The extra copy of this Bill of Lading, furnished at the time of shipment, must be attached to the freight bill submitted to Shipper or the "Billed to" party and sent to:

CONSIGNED TO:

CES Environmental Services, Inc.

4904 Griggs Rd.

(281) 328-3501

Houston, TX 77021

CARRIER:

11c)

CES Environmental Services, Inc.

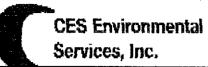
4904 Griggs Rd.

Houston, TX 77021

This is to certify that the product stated below are properly classified, described, packaged, marked and labeled and is in proper condition for transportation according to the applicable regulations of the Department of Transportation. If this Shipment moves between to ports by a certier by water, the law requires that the Bill of Lading shall state whether it is "carried's or shipper's weight."

Intermodal Certificate: All Information required by Federal Highway Administration regulations at 49 CFR 390.542 implementing the intermodal 8afe Container Act of 1992 is set forth on the face of this bill of lading. The shipper name herein is the tendering party.

| Haz | Cont | alner | Total | Unit | Description of Materials, Special Marks, and | Exceptions |
|-------|--------------|------------|----------|----------|--|---------------------------------|
| ' | No. | Туре | Quantity | Wt/Vol | | |
| Yes | 1 | TT | 41320 | F | RQ, Corrosive, liguid, basic, inorganic (sodium hy | droxide), 8, UN3266, PG II |
| | | | | _ | | |
| | | | | | | |
| Ship | per: | кмсо | , Inc. | <u> </u> | | |
| Per : | <u>-</u> | bn | Brya | Phi | Signature: Www. | Date: 13-03-0 |
| Carri | er C | ES Env | /ironmen | tal Sen | vices, Inc. | |
| Per : | : <u>K</u> . | UiA | CR | اں 4 | Fignature: King | Date: 12-3-08 |
| Rece | iving | Facilit | y:CES | Enviror | imental Services, Inc. | |
| Рег | | ode | 107 | | Signature: | Date: 12-3-08 |
| White | (Gधाशत | ior Return | Сөру) | Yellow i | Transporter Copy) Pink (Receiving Facility Copy) | Golden Rod (Generator 1st Copy) |





Bill Of Lading #:

77087

| Folder ID: KMCO (KMCO - Crosby, 7 SIB Hazardous Westewsk | |
|---|--|
| Original – Shipper Provided Short I | Form Straight Bill of Lading – Not Negotiable – Domestic |
| SHIPPED FROM: | • |
| KMCO, Inc. | 11a) PA-2804 |
| 16503 Ramsey Rd. | 11b) |
| Crosby , TX 77532 | 11c) |
| (281) 328-3501 | 11c) |
| The property described below, in apparent good order, e | a cept as noted (content and condition of packages unknown), marked, consigned, and destined as indicated below, which |

said carrier (the word carrier being understood throughout this as meaning any person or corporation authorized to be in possession of the property under the contract) agrees to carry to its unusual place of delivery at said destination. This Bill of Lading is a receipt for goods, it is not of itself a contract of carriage, it is mutually agreed, as to each carrier of all or as to any said over all or any portion of said route to destination, and as to each party at any time interested in all or any of said properly, that every service to be performed hereunder shall be subject to all the terms and conditions contained in the applicable contract between shipper and carrier or intermediany.

For payment: Charges to be billed to Shipper or the "Billed to" party are set forth in the governing contract with Shipper. No charges other than those contained therein may be billed to Shipper or the "Billed to" party without prior written consent of Shipper. The extra copy of this Bill of Lading, furnished at the time of shipment, must be attached to the freight bill submitted to Shipper or the "Billed to" party and sent to:

CONSIGNED TO:

CES Environmental Services, Inc.

4904 Griggs Rd.

Houston, TX 77021

CARRIER:

CES Environmental Services, Inc.

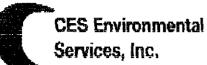
4904 Griggs Rd.

Houston, TX 77021

This is to certify that the product stated below are properly classified, described, packaged, marked and labeled and is in proper condition for transportation according to the applicable regulations of the Department of Transportation. If this Shipment moves between to ports by a camer by water, the law requires that the Sill of Lading shall state whether it is "carrier's or shipper's weight."

Intermodal Certificate: All information required by Federal Highway Administration regulations at 43 CFR 390.548 implementing the Intermodal Rafe Container Act of 1992 is set forth on the face of this bill of lading. The shipper name herein is the tendering party.

| Haz Container | | ainer | Total Unit | | Description of Materials, Special Marks, and Exceptions | | |
|---------------|------------|------------|------------|-----------|---|--|--|
| | No. | Type | Quantity | WtVol | · | | |
| Yes | 1 | TT | 40201 |) P —— | RQ, Corrosive, liquid, basic, inorganic (sodium hydroxide), 8, UN3266, PG II | | |
| | | · = | <u> </u> | | | | |
| | | | | | A | | |
| Ship | per: | кмср | Inc. | 1/ | | | |
| Per | | D-W : | Buta | 1_ | Signature: New Juya Date: 12/4/03 | | |
| Carr | ier y | ĘS Env | /ironmen | tal Ser | vices, Inc. | | |
| Per | fol | AND | o (ARR | 116 | Signature: Comb Carille Date: 13-04-08 | | |
| Rec | eiving | Facilit | y : CES | Enviror | nmental Services, Inc. | | |
| Per | : Ba | can_ | Weat | hus | Signature / Date: | | |
| White | e (General | tor Return | Сору) | Yellow | (Transporter Copy) Pink (Receiving Facility Copy) Golden Rod (Generator 1st Copy) | | |



White (Generator Return Copy)

Yellow (Transporter Copy)

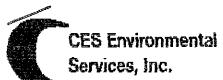
Bill Of Lading #:

77088

| W | S | ervice | es, inc. | | | |
|---|---|--|--|---|---|---|
| Folder | ID : | | O (KMCO - 4 Hazardous V | | () | |
| _ | SI | піррег | Provided | Short F | orm Straight Bill of Lading – Not Negotiable – Domestic | |
| . .io | PED I | RON | 7 : | | | |
| KMC | O, Ind | | | | 11a) PA-28 ⁿ * | |
| | 3 Ran | _ | | | 116 | |
| | οу , Τ', | | 32 | | 110 | |
| (231) | 328-3 | 3501 | | | 11c) | |
| sald carri ry to it goods; it retime between: | er (the wo ts unusual is not of its interested shipper an | rd camer i place of d self a contu in all or an d camer o es to be bl | being understog elivery at said o ract of carriage. ny of said prope x intermediany. Hed to Shipper | ed throughous lestination, h It is mutually ity, that ever or the "Billed | cept as noted (content and condition of packages unknown), marked, consigned, and destined as indicated below, this as meaning any person or corporation authorized to be in possession of the properly under the contract) agre- f on its route, otherwise to deliver to another carrier on the route to said destination. This Bill of Lading is a receipt to y agreed, as to each carrier of all or as to any said over all or any portion of said route to destination, and as to each y service to be performed hereunder shall be subject to all the terms and conditions contained in the applicable could be performed thereunder shall be subject to all the terms and conditions contained in the applicable could be performed thereign contract with Shipper. No charges other than those contained therein may be sent of Shipper. The extra copy of this Bill of Lading, furnished at the time of shipprent, must be attached to the first | for th party : oniract be billed |
| | | | Med to party as | | and of only part the orang to make the | gin 6.71 |
| CON | SIGNE | ED TO |): | | CARRIER: | |
| | Invira | nmen | ital Servi | ces, Ind | c. CES Environmental Services, Inc. | |
| | Gngg | | | | 4904 Griggs Rd. | |
| | ton , T | | | | Houston , TX 77021 | |
| annlicable It is "carrie annda | : regulation er's or strip : Centificat | es of the Di oper's welf e: All Infor | epariment <i>of</i> Tra gist." mation required | areportation ity Federal | classified, described, packaged, marked and labeled and is in proper condition for transportation according to the If this Bripment moves between to ports by a carrier by water, the law requires that the Bill of Lading shall state w Highway Administration regulations at 49 CFR 330.54© implementing the intermodal 8 afe Container Act of 1992 i rein is the tendering party. | ol septe |
| Lar! | Contat | 11 0 1 | Total | Unit | Description of Materials, Special Marks, and Exceptions | |
| ' <u></u> | No. | Туре | Quantity | MAAOU | | |
| Yes | 1 | 77 | 45960 | P | RQ, Corrosiye, liquid, basic, inorganic (sodium hydroxide), 8, UN3268, PC | 3 'I |
| | | | | | | |
| Shipp | er : K | MCQ | , inc. | | | ′ |
| per: | Do | nE | ryan | <u> </u> | Signature: Down Date: 12146 | 35 |
| Carrie | r <u>CE</u> | S Env | rironmen | tal Ser | vices, Inc. | |
| Per: | | | | , | Signature: Care Date: 12-Y-C | <u>> 8</u> |
| Recei | ving ʃ | acilit | y:CES | Enviror | nmental Services, Inc. | |
| Per: | bo | ian . | Heath | | Signature : Date : | |

Pink (Receiving Facility Copy)

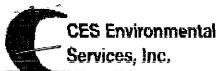
Golden Rod (Generator 1st Corre



Bill Of Lading #:

77089

| Folder ID : | KMCO (KMCO - | Creaby, TX | | | |
|--|--|--|---|---|---|
| | SIB Hazardous V | | | | |
| | | Short Fo | ımı Straight Bill o | f Lading – Not Negotiable – Do | omestic |
| SHIPPED FI | RON: | | | | · |
| KMCO, Inc. | | | | 11a) PA-2804 | |
| 16503 Rams | - | | | 11b) | |
| Crosby , TX 77532 | | | | 11c) | |
| (281) 328-35 | oQ1 | | | 11c) | |
| said carrier (the word carry to its unusual pin goods; it is not of itself any time interested in between shipper and of For payment. Charges | carrier being undersioned of delivery at said of a contract of carriage all or any of said proposerrier or intermediary to be billed to Shipper to be billed to Shipper to be party without price to "party without price to "party without price at the said of the said without price at the said without price to "party without price at the said with the said without price at the said with the said without without price at the said with | ad throughout destination, if this mutually enty, that even or the "Billed realten cons | this as meaning any person on its route, otherwise to del agreed, as to each carrier or service to be performed he to [*] party are set forth in the | ndition of packages unknown), marked, consign or corporation sufficing of to be in possession of iver to another center on the route to said destin if all or as the carrier said over all or any portion of s reunder shall be subject to all the terms and cor governing contract with Shipper. No charges oth of this Sill of Lading, furnished at the time of s | the properly under the contract) agrees to salon. This Bill of Lading is a receipt for aid route to destination, and as to each party additions contained in the applicable contract er than those contained therein may be billed. |
| CONSIGNE | | 810 SCH 10. | | CARRIER: | |
| CES Environ | | ices Ind | <u>.</u> | CES Environmental Serv | ices inc |
| 4904 Griggs | | ioca, iii | 1- | 4904 Griggs Rd. | nood, me. |
| Houston, T) | | | | Houston , TX 77021 | |
| Haz Containe | المالية المالية المالية المالية المالية المالية المالية المالية المالية المالية المالية المالية المالية المالية | Unit | | ion of Materials, Special Marks, an quid, basic, inorganic (sodium h | |
| Receiving Fa | Environment CR | ital Serv ム いい Environ | Signature: | Crawly, Inc. | Date: 12-5-08 Date: |
| White (Generator F | | | Signature : | Pink (Receiving Facility Copy) | Golden Rod (Generator 1st Copy) |



#7253Bill Of Lading #:

77372

| | 2 | <u> GLAIC</u> | es, mc. | | |
|---|--|--|---|---|--|
| Fold | er ID : | | O (KMCO Hazardoue V | | |
| Orig | jinal – S | hipper | Provided | Short F | orm Straight Bill of Lading – Not Negotiable – Domestic |
| SHI | PPED | FRON | 1: | | |
| ΚM | CO, Inc | C. | | | 11a) PA-2804 |
| 165 | 03 Rar | nsey l | ₹d. | | 11b) |
| Cro | sby , T | X 775 | 32 | | 11c) |
| (28 | 1) 328- | 3501 | | | 11c) |
| sadc cary i goods ary tir behve | amer (the wallo its unusual); It is not of it ne interested en shipper a | ord carrier I place of d Iself a comi I in all or a nd carrier (| being undersion lettvery at said ract of carriage ny of said prope or Intermediany. | od throughou destination, i . It is mutual sty, that exe | cept as noted (content and condition of packages unknown), marked, consigned, and destined as indicated below, which if this as meaning any person or corporation authorized to be in possession of the property under the contract) agrees to fight it route, otherwise to deliver to another carrier on the route to said destination. This Bill of Lading is a receipt for by agreed, as to each carrier of all or as to any said over all or any portion of said route to destination, and as to each party a by service to be performed hereunder shall be subject to all the terms and conditions contained in the applicable contract |
| to Ship | per or the "E | illed to pa | | r written con | d to" party are set forth in the governing contract with Shipper. No charges other than those contained therein may be billed sent of Shipper. The extra copy of this Bill of Lading, furnished at the time of shipment, must be attached to the freight bill. |
| CO | NSIGN | ED TO |) : | | CARRIER: |
| CES | Enviro | onmen | ital (Port | Arthur |) CES Environmental Services, Inc. |
| 242 | 0 Gulfv | vay Dr | | | 4904 Griggs Rd. |
| Port | t Arthui | -, TX | 77640 | | Houston , TX 77021 |
| Haz | Conta | | Total Quantity | Unit | Description of Materials, Special Marks, and Exceptions |
| Yes — - | 1 | 11 | 4316C |) P | RQ, Corrosive, liquid, basic, inorganic (sodium hydroxide), 8, UN3266, PG II |
| | | | | | |
| Shin | per: k | MCO | -Inc. | | |
| Per | Po | 4 | Bryca | in | Signature: NOW Ma Date: 19-9-08 |
| Carri | ier <u>CE</u> | S Env | /ironmen | tal Ser | vices, Inc. |
| Per | : <u>[[] [</u>] | ling | n Den | ton_ | Signature: Date: 12/9/08 |
| Rece | eiving l | Facilit | y:CES | Enviror | nmental (Port Arthur) |
| Per | : <u>G</u> | de | 101 | ····· | Signature: Date: 12/9/08 |
| White | (Generato | r Return | Copy) | Yellow | (Transporter Copy) Pink (Receiving Facility Copy) Golden Rod (Generator 1st Copy) |



Bill Of Lading #:

77373

| Folder ID : | KMCO (KMCO - SIB Hazardous) | | | | |
|---|---|---|--|--|--|
| Original – Sh | ipper Provided | Short For | n Straight Bill of | Lading – Not Negotiable - | Domestic |
| SHIPPED F | ROM: | | | | |
| KMCO, Inc | • | | | 11a) PA-2804 | |
| 16503 Ram | isey Rd. | | | 11b) | • |
| Crosby, TX | (77532 | | | 11c) | |
| (281) 328-3 | 501 | | | 11c) | |
| said carrier (the wor carry to its unusual p goods; it is not of its any time interested (| d carrier being undersio piace of delivery at said elf a contract of carriage | ed throughout this destination, if on this mutually again, that enty, that every a | s as meaning any person o its route, otherwise to delik preed, as to each carrier of | r corporation authorized to be in possessi- er to another carrier on the roule to said d all or as to any said over all or any portion | signed, and destined as indicated below, which on of the property under the contract) agrees to estination. This Bill of Lading is a receipt for i of said route to destination, and as to each party at i conditions contained in the applicable contract |
| to Shipper or the "Bill | | r witten consen | | | s other than those contained therein may be billed e of stippment, must be attached to the freight bill |
| CONSIGNE | D TO: | , | · · · · · · · · · · · · · · · · · · · | CARRIER: | |
| CES Environ | nmental (Port | Arthur) | | CES Environmental S | ervices, Inc. |
| 2420 Gulfwa | ay Dr. | - | | 4904 Griggs Rd. | · |
| Port Arthur | , TX 77640 | | | Houston, TX 77021 | |
| applicable regulations It is "carrier's or ship intermodal Centricate | s of the Department of T per's weight." :: All information require | ansportation. If to d by Federal Hig | rits Shipmert moves betwe hway Administration regul | | ndition for transportation according to the equires that the Bill of Lading shall state whether to intermedial Bafe Container Act of 1992 is set |
| forth on the face of thi | s bill of lading. The ship | per name hereln | is the tendering party. | | |
| Haz Contain No. | Type Total Quantity | Unit WWol | Descripti | on of Materials, Special Marks, | and Exceptions |
| Yes 1 | тт Д926 6 |) F | RQ, Carrosive, lic | juid, basic, inorganic (sodiun | n hydroxide), 8, UN3266, PG II |
| | | | | Λ | |
| Shipper : Kl Per : | MCO, Inc. | yail : | Signature : | Un Buja | Woate: 129-8 |
| Carrier CES | S Environmen | tal Servic | es, Inc. | , | |
| | in Wil | | | Wilm | Date: 12.9.08 |
| Receiving F | acility : CES | Environm | ental (Port Arti | nur) | \$\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\ |
| Per : | | | Signature: | | Date : |
| White (Generator | Return Copy) | Yellow (Tra | nsporter Copy) | Pink (Receiving Facility Copy) | Golden Rod (Generator 1st Copy) |

CES Environmental Services, Inc.

Bill Of Lading #:

77374

| 7 | | ervic | es, inc. | | |
|---|--|--|---|--|--|
| Fold | ier ID : | | O (KMCO - Hazardous V | | |
| Orig | ginal – S | / L Shipper | Provided | Short F | orm Straight Bill of Lading – Not Negotiable – Domestic |
| SH | IPPED | FRON | A : | | |
| ΚM | ICO, In | iC. | - - | | 11a) PA-2804 |
| | 503 Rai | | Rd. | | 11b) |
| Cre | r, ydad | ΓΧ 77̄5 | 32 | | 11c) |
| (28 | 1) 328 | -3501 | | | 11c) |
| said (carry good: arry ti betwee | carrier (the vide to its unusures; it is not of irrieresto sensity of the symmetric characters; charac | word carrier ini place of o itself a com ed in all or a and carrier o rges to be b | being understo lelivery at said ract of carriage my of said prop or intermediary. Illed to Shipper | od throughou destination, this mutual erty, that eve or the "Bille | cept as noted (content and condition of packages unknown), marked, consigned, and destined as indicated below, which if this as meaning any person or corporation authorized to be in possession of the property under the contract) agrees to if on its route, otherwise to deliver to another carrier on the route to said destination. This Bill of Lading is a receipt for liy agreed, as to each carrier of all or as to any said over all or any portion of said route to destination, and as to each party by service to be performed hereunder shall be subject to all the terms and conditions contained in the applicable contract d to party are set forth in the governing contract with Shipper. No charges other than those contained therein may be billed seent of Shipper. The extra copy of this Bill of Lading, furnished at the time of shippers, must be attached to the felight bill |
| | | | illed to" party a | | See See See See See See See See See See |
| CO | NSIGN | ED TO |): | | CARRIER: |
| | | | ital (Port | Arthur | CES Environmental Services, Inc. |
| | O Guth | - | | | 4904 Griggs Rd. |
| | t Arthu | | | | Houston, TX 77021 classified, described, packaged, marked and labeled and is in proper condition for transportation according to the |
| forth o | on the face of Conts | ites bli of la | Total Quantity | Unit Wt/Vol | Highway Administration regulations at 49 CFR 390.54© implementing the Intermodal Safe Container Act of 1992 is set rein is the tendering party. Description of Materials, Special Marks, and Exceptions |
| | No. | Туре | | | |
| Yes — . | 1 | <u> </u> | 46840 | P | RQ, Corrosive, liquid, basic, inorganic (sodium hydroxide), 8, UN3266, PG II |
| | | | | | |
| Chi n | per : _! | KMCO. | . Inc. | | |
| er. Per | Too | \ \ \ | 1/ = | | Signature: Dufan Date: 12 10 8 |
| rei | .— | JVVV | Dryai | <u>'U</u> | Signature: WWW Date: 15 10 C |
| Carr | ier <u>C</u> E | ES Env | ironmen | tal Sen | vices, Inc. |
| Per | : <u>Wi</u> | Miar | n Den | ton | Signature: William Date: 10/08 |
| Rece | eiving | Facilit | y:CES | Enviror | nmental (Port Arthur) |
| Per | :: | , 500 | refro | 1 | Signature : Date : Do (|

Pink (Receiving Facility Copy)

Yellow (Transporter Copy)

White (Generator Return Copy)

Golden Rod (Generator 1st Copy)

CES Environmental Services, Inc.

Bill Of Lading #:

77376

| Folder ID: KMCO (KMCO - Croeby, TX) SIB Hazardoue Wastewaler | |
|--|---|
| Original - Shipper Provided Short Form S | Straight Bill of Lading – Not Negotiable – Domestic |
| SHIPPED FROM: | |
| KMCO, Inc. | 11a) PA-2804 |
| 16503 Ramsey Rd. | 11b) |
| Crosby, TX 77532 | 11c) |
| (281) 328-3501 | 11c) |

The property described below, in apparent good order, except as noted (content and condition of packages unknown), marked, consigned, and destined as indicated below, which said carrier (the word carrier being understood foroughout this as meaning any person or corporation authorized to be in possession of the property under the contract) agrees to carry to its unusual place of delivery at said destination, if on its route, otherwise to deliver to another carrier on the route to said destination. This Bill of Lading is a receipt for goods; it is not of itself a contract of carriage, it is mutually agreed, as to each carrier of all or as to any said over all or any portion of said route to destination, and as to each party at any time interested in all or any of said property, that every service to be performed bereunder shall be subject to all the terms and conditions contained in the applicable contract between shipper and carrier or intermediary.

For payment: Charges to be billed to Shipper or the "Billed to" party are set forth in the governing contract with Shipper. No charges other than those contained therein may be billed to Shipper or the "Billed to" party without prior written consent of Shipper. The extra copy of this Bill of Lading, furnished at the time of shipment, must be attached to the fieldhi bill submitted to Shipper or the "Billed to" party and sent to:

CONSIGNED TO:

CES Environmental (Port Arthur)

2420 Gulfway Dr.

Port Arthur, TX 77640

CARRIER:

CES Environmental Services, Inc.

4904 Griggs Rd.

Houston, TX 77021

This is to certify that the product stated below are properly classified, described, packaged, marked and labeled and is in proper condition for transportation according to the applicable regulations of the Department of Transportation. If this Shipment moves between to ports by a carrier by water, the law requires that the Bill of Lading shall state whether it is "carrier's or shipper's weight."

Intermodal Certificate: All Information required by Federal Highway Administration regulations at 49 CFR 390.546 implementing the intermodal 8 ate Container Act of 1992 is set forth on the face of this bill of lading. The shipper name herein is the tendening party.

| Haz | laz Container | | Confainer | | Container | | Z Confainer | | Total | Unit | Description of Materials, Special Marks, and Exceptions |
|---------|---------------|---|-----------|--------------------|---|--|-------------|--|-------|------|---|
| | No. | Type | Quantity | ₩tVoi | | | | | | | |
| Yes | 1 | 77 | 39,420 |) F | RQ, Corrosive, liquid, basic, inorganic (sodium hydroxide), 8, UN3266, PG II | | | | | | |
| | | 20 100-200-200-200-200-200-200-200-200-200- | | | | | | | | | |
| Ship | per:_ | KMCO | , Inc. | | | | | | | | |
| Per | : 101 | y Sa | indles J | <u> </u> | Signature: Tuy Sandles 12 Date: 12/11/2008 | | | | | | |
| Carr | ier <u>C</u> | ES Env | vironmen | tal Ser | vices, Inc. | | | | | | |
| Per | : | Brev | nt Si | Tig | Signature: Dient Sitting Date: 18/11/08 | | | | | | |
| Rece | eiving | Facili | ty : CES | <i>O</i> Enviro | nmental (Port Arthur) | | | | | | |
| Per | : | od | e(n) | 4 | Signature : Date : Date : Date : | | | | | | |
| VViille | (Genera | tor Retum | Сору) | Yellow | (Transporter Copy) Pink (Receiving Facility Copy) Golden Rod (Generator 1st Copy) | | | | | | |

+11.#255



Bill Of Lading #:

77377

| Folder ID: KMCO (KMCO - Crosby, TX) | | |
|--|---|--|
| SIB Hazardous Wastewater | | |
| Original – Shipper Provided Short Form | Straight Bill of Lading – Not Negotiable – Domestic | |
| SHIPPED FROM: | | |
| KMCO, Inc. | 11a) PA-2804 | |
| 16503 Ramsey Rd. | 115) | |
| Crosby , TX 77532 | 11c) | |

The property described below, in apparent good order, except as noted (content and condition of packages unknown), marked, consigned, and destined as indicated below, which said carrier (the word carrier being understood throughout this as meaning any person or corporation authorized to be in possession of the property under the contract) agrees to carry to its unusual place of delivery at said destination, if on its route, otherwise to deliver to another carrier on the route to said destination. This Bill of Lading is a receipt for goods; it is not of itself as contract of carriage, it is mutually agreed, as to each carrier of all or any portion of said route to destination, and as to each party at any time interested in all or any of said property, that every service to be performed hereunder shall be subject to all the terms and conditions contained in the applicable contract between shipper and carrier or intermediary.

For payment. Charges to be billed to Shipper or the "Billed to" party are set forth in the governing contract with Shipper. No charges other than those contained therein may be billed to Shipper or the "Billed to" party without prior written consent of Shipper. The extra copy of this Bill of Lading, furnished at the time of shipment, must be attached to the field to bill submitted to Shipper or the "Billed to" party and sent to:

CONSIGNED TO:

(281) 328-3501

CES Environmental (Port Arthur)

2420 Gulfway Dr.

Port Arthur, TX 77640

CARRIER:

11c)

CES Environmental Services, Inc.

4904 Griggs Rd.

Houston, TX 77021

This is to certify that the product stated below are properly classified, described, packaged, marked and labeled and is in proper condition for transportation according to the applicable regulations of the Department of Transportation. If this Shipment moves between to ports by a carrier by water, the law requires that the Still of Lading shall state whether it is "carrier's or shipper's weight."

Intermodal Cartificate: All information required by Federal Highway Administration regulations at 49 CFR 330.54© Implementing the Intermodal Safe Container Act of 1992 is set forth on the face of this bill of lading. The shipper name herein is the tendering party.

| Haz | Cont | Container Total Unit Description of Materials, Special Marks, and Exceptions | | | | | |
|-------------|------------|--|--------------------|--------------------|--|-----|--|
| | No. | Туре | Quantity | W t/Vol | | | |
| Yes | Í | TT | 3964 6 |) F | RQ, Corrosive, liquid, basic, inorganic (sodium hydroxide), 8, UN3266, PG II | | |
| | | | | | | | |
| | | | | | | | |
| | | | _ | | | | |
| | · | | | | | | |
| | | · | | | \sim \sim \sim \sim | , | |
| Ship | per_: | KMCO | , Inc. | | | | |
| Per | =_4 |) on | 5 | 'xan | Signature: Voullyan Date: 12-10- | 100 | |
| _ | . <u>^</u> | F8 F | .: | (*=1 *3== | | .) | |
| | | | | | vices, Inc. | | |
| Per | : B | cent | S:#:9 | <u></u> | Signature: Bunt Sitty Date: 12/12/08 | | |
| Reci | aivina | Facilii | <i>0</i> w ∙CES | Enviror | nmental (Port Arthur) | | |
| | : (. | | | | | 80 | |
| Per | | > 0 0 | ~_ | - | Signature: 12 12 | ی د | |
| \A/hita | e (Generat | or Return | Capvi | J Yellow | (Transporter Copy) Pink (Receiving Facility Copy) Golden Rod (Generator 1st Cop) | ħ) | |

CES Environmental Services, Inc.

Bill Of Lading #:

77378

| | KMCO (KMCO - Crosby, TX) SIB Hazardous Wastewater | | | | | | | |
|-------------------|--|--------------|--|--|--|--|--|--|
| Original – Shi | Original – Shipper Provided Short Form Straight Bill of Lading – Not Negotiable – Domestic | | | | | | | |
| SHIPPED FI | ROM: | | | | | | | |
| KMCO, Inc. | | 11a) PA-2804 | | | | | | |
| 16503 Ramsey Rd. | | 11b) | | | | | | |
| Crosby , TX 77532 | | 11c) | | | | | | |
| (281) 328-35 | 501 | 11c) | | | | | | |

The property described below, in apparent good order, except as noted (content and condition of packages unknown), marked, consigned, and destined as indicated below, which said carrier (the word carrier being understood inroughout this as meaning any person or corporation authorized to be in possession of the property under the contract) agrees to carry to its unusural place of delivery at said destination, if on its route, otherwise to deliver to another carrier on the route to said destination. This Bill of Lading is a receipt for goods; it is not of listely a contract of carriage, it is mutually agreed, as to each carrier of all or as to any said over all or any portion of said route to destination, and as to each party at another interested in all or any of said property, that every service to be performed hereunder shall be subject to all the terms and conditions contained in the applicable contract between shipper and carrier or intermediary.

For payment, Charges to be billed to Shipper or the "Billed to" party are set forth in the governing contract with Shipper. No charges other than those contained therein may be billed to Shipper or the "Billed to" party without prior written consent of Shipper. The extra copy of this Bill of Lading, furnished at the time of shipment, must be attached to the freight bill submitted to Shipper or the "Billed to" party and sent to:

CONSIGNED TO:

CES Environmental (Port Arthur)

2420 Gulfway Dr.

Port Arthur, TX 77640

CARRIER:

CES Environmental Services, Inc.

4904 Griggs Rd.

Houston, TX 77021

This is to certify that the product stated below are properly classified, described, packaged, marked and labeled and is in proper condition for transportation according to the applicable regulations of the Department of Transportation. If this Shipment moves between to ports by a carrier by water, the law requires that the Bill of Lading shall state whether it is "carrier's or shipper's weight."

Intermodal Certificate: All Information required by Federal Highway Administration regulations at 49 OFR 330,546 implementing the intermodal Safe Container Act of 1997 is set forth on the face of this bit of lading. The shipper name herein is the tendering party.

| Haz Container | | Container | | Container | | Unit | Description of Materials, Special Marks, a | nd Exceptions |
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Claim & Information Services P.O. Box 12029

Austin, TX 78711-2029

(512) 224-3800 1-800-859-5995

> Fax (512) 224-3889

December 22, 2008

Family of JOEY SUTTER 2420 GULFWAY DRIVE PORT ARTHUR TX 77640

Re:

Claim #:

JOEY SUTTER

Employee: Employer:

C E S ENVIRONMENTAL SERVI

Date of Injury: 12/18/2008

DWC #:

Dear Family of SUTTER, JOEY,

Please accept my condolences on your loss. I am the workers' compensation specialist assigned to process this claim.

I am writing to contact you by sending this letter to advise that we are currently investigating the claim that was reported by the employer.

Please call 1-800-859-5995, extension 7291to contact me and discuss this claim. I thank you in advance for your cooperation.

Sincerely,

Karin T. Crouse

CAT WORKERS' COMP SPEC II

Cc: CES Environmental Services Inc.



Claim & Information Services P.O. Box 12029

Austin, TX 78711-2029

1-800-859-5995 (512) 224-3800

Fax (512) 224-3889

December 22, 2008

C E S ENVIRONMENTAL SERVI ATTN: CARL GUIDRY 4904 GRIGGS RD

HOUSTON, TX 77021-3208

Re:

Claim #:

Employee: Soc. Sec.:

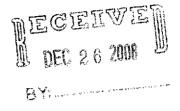
Employer: Date of Injury: C E S ENVIRONMENTAL SERVI

12/18/2008

JOEY SUTTER

401-08-2362

DWC#:



In accordance with the Division of Workers' Compensation Rules, we are requesting that you submit the information indicated below. The DWC3 and DWC6 forms are available for printing from our website, www.texasmutual.com, under services, or from the division's website, www.tdi.state.tx.us. For your convenience, a DWC3 is now available for you to complete and submit on-line. It is located on our website, www.texasmutual.com under the Employers - Loss Run & Claims Detail Section. If you need assistance with filing the DWC3 on-line please contact me. If you do not have access to the Internet, we will be happy to send you a blank form.

 \boxtimes DWC3 EMPLOYER'S WAGE STATEMENT (Rule 128.2) - Please fax or email attachment or use the on-line version (www.texasmutual.com).

OR

DWC3SD EMPLOYER'S WAGE STATEMENT FOR SCHOOL DISTRICTS (Rule 128.7)

DWC6 EMPLOYER'S SUPPLEMENTAL REPORT OF INJURY OR ILLNESS (Rule 120.3) - Please fax or email \boxtimes attachment. The following time frames apply.

Within 10 days after:

- The end of each pay period in which the employee's earnings have changed as a result of the injury, OR
- The employee resigns or is terminated.

Within 3 days after:

- The employee begins to lose time from work as a result of the injury, OR
- The employee returns to work, OR
- The employee, after returning to work experiences an additional days(s) of disability as a result of the injury.

Failure to provide the required information is an administrative violation and may result in the assessment of a penalty from the Division of Workers' Compensation.

AND

 \boxtimes EMPLOYEE ACKNOWLEDGEMENT OF WORKERS' COMPENSATION NETWORK FORM (This form(s) shall be completed, signed and submitted). Please fax or send attachment via email as soon as possible.

X COPY OF THE POST-ACCIDENT DRUG SCREEN RESULTS

Thank you for your prompt attention to this matter. If you have any questions, please call me at 1-800-859-5995 ext.7291.

Sincerely,

Karin T. Crouse

CAT WORKERS' COMP SPEC II



12/23/2008

Texas Department of Insurance Division of Workers' Compensation



CES ENVIRONMENTAL SERVICES INC 4904 Griggs Rd Houston, TX 77021-3208 RE: Claim No.:

Injured Worker:

Date of Injury:

Carrier Name: Carrier No.: JOEY SUTTER 12/18/2008

Texas Mutual insurance Co

99J0000556027

NOTICE TO EMPLOYER

The Texas Department of Insurance, Division of Workers' Compensation (DWC) has received notice of an injury/death on the above-named employee. Enclosed is information about your rights and responsibilities as an employer and information to help you develop successful return to work procedures. Services available from DWC to assist employers include:

RETURN TO WORK SERVICES: DWC provides information to help employers reduce costs and control lost time by successfully returning injured workers to productive work as soon as possible following an injury. A "Resource Guide" and other information are available on DWC website. In addition, workshops, seminars, and individual consultations also are available.

<u>OSHCON</u> - Free health and safety consultations are provided to small private employers on request. Emphasis is placed on assisting the employer in developing effective health and safety programs and identifying and correcting hazards in the workplace, including industrial hygiene testing.

<u>Safety Information Library</u> - Health and safety training programs are available to employers, employees, academic institutions and other entities in Texas. Additionally, the Division maintains a resource center containing health and safety information, visual aids, and publications. A large number of safety educational materials are available for download from the Division's web site. The Division staff also provide assistance with research on specific health and safety issues and questions.

<u>Safety Education & Training</u> - Onsite professional occupational safety training is available to public and private employers throughout the State of Texas. We can help any Texas business, whether or not the company subscribes to workers' compensation.

More information on these services can be located on the Division's website at www.tdi.state.tx.us.

Your workers' compensation insurance carrier is required to notify you of any claim filed against your policy. You may submit a written request to your insurance carrier to secure additional information regarding payments, reserves, and the effect on premium rates set by the Texas Department of Insurance. This information is intended to inform you of the means to secure specific information regarding your company's workers' compensation claims. Please direct your questions regarding premium rates to the Texas Department of Insurance, Workers' Compensation Division, 333 Guadalupe Street, Austin, Texas 78701 (telephone 512-322-3495).

If you prefer this information be mailed to an address other than 4904 Griggs Rd, Houston, TX 77021-3208, please contact your workers' compensation insurance carrier, who will advise the Division of any address changes. Future mailings will be forwarded to the corrected address.

THIS NOTICE DOES NOT REQUIRE A RESPONSE.

Sincerely,

Texas Department of Insurance, Division of Workers' Compensation

Enclosure: Rights and Responsibilities

Employer Rights and Responsibilities under the Texas Workers' Compensation Act

For further information about your rights and responsibilities, please refer to the Texas Workers' Compensation Act (Texas Labor Code, Title 5, Subtitle A) and to the administrative rules of the Texas Department of Insurance, Division of Workers' Compensation. For specific information, please write the Division at 7551 Metro Center Drive, Suite 100, Austin, TX 78744-1609, or call 1.800,252.7031 to be connected to the field office nearest you or

EMPLOYER RIGHTS

The Texas Workers' Compensation Act, Texas Labor Code, Section 409.011, provides covered employers the following rights:

- to be present at all administrative proceedings related to a claim
- To present relevant evidence related to a claim at any proceeding
- to report suspected fraud
- to contest the compensability of an injury if the insurance carrier accepts liability for the payment of benefits.
- to receive notice, after making a written request to the insurance carrier, of
 - an administrative or a judicial proceeding related to the resolution of a claim; or
 - · a proposal to settle a claim
- to contest the failure of the insurance carrier to provide accident prevention services required by the Act.

EMPLOYER RESPONSIBILITIES

1) Reporting Injuries

Employer's First Report of Injury: You must report <u>to your insurance carrier</u> within 8 days of the date you receive notice or have knowledge of:

- a work-related injury that causes an employee to miss more than 1 day of work
- an occupational illness that you know about, even if the employee has not missed any work
- · a work-related death

Do not file an employer's First Report of Injury with the Texas Department of Insurance, Division of Workers' Compensation unless specifically requested to do so.

You may report injuries by mail, fax, telephone, or electronic transmission to your insurance carrier. Failure to timely report an injury or illness may result in an administrative penalty not to exceed \$500 to be assessed by the Division. Send a copy to the injured worker and provide the employee a summary of rights and responsibilities in the wording adopted by the Division.

You must keep a record of work-related injuries, illnesses, and deaths. Keep the records for at least 5 years from the last day of the year in which the injury, illness, or death occurred, or for the period of time required by the Occupational Safety and Health Administration, whichever is greater.

2) Other Reporting Responsibilities

Employer's Wage Statement:

You must report an injured worker's wages and other compensation to your insurance carrier. Send Form-3, Employer's Wage Statement, to your insurance carrier within 30 days of the date income benefits begin to accrue. Send a copy of the form to the injured worker. Do not file the form with the Division unless specifically requested to do so.

Supplemental Report of Injury: You must report any changes in an injured worker's pay or employment status to your insurance carrier. Send Form-6, Supplemental Report of Injury, to your insurance carrier within:

- 3 days of the date the injured worker returns to work;
- 3 days of the date an injury causes the employee to miss additional work after returning to work;
- 10 days of the end of a pay period in which the injured worker's weekly earnings change as a result of the injury;
- 10 days of the date the injured employee resigns or is terminated.

Send a copy of the form to the injured worker. Do not file the form with the Division unless specifically requested to do so.

If you do not timely send the required forms to the insurance carrier and the injured worker, you could be subject to a penalty of up to \$500 per occurrence for the Employer's Wage Statement and the Supplemental Report of Injury.

3) Posting and Notice Responsibilities

(This section does not apply to Political Subdivisions)

Notice of Coverage or Change in Coverage: You must post notices in your workplace telling your employees that:

- You have workers' compensation insurance and provide the name of your workers' compensation insurance carrier;
- the Division has staff to explain injured workers' rights and responsibilities and to help resolve disputes about their claims;
- the Division has a 24-hour, toll free hotline to report suspected safety violations in the workplace.

Posted notices must be in wording and format adopted by the Division. If you do not post these notice, you could be subject to a penalty up to \$500.

You must give all of your employees written notice if you cancel your workers' compensation policy within 15 days of the date you cancel your policy or are notified that your insurance carrier intends to cancel you policy. If you do not provide this notice to your employees, you could be subject to a penalty up to \$500 per occurrence.

Employer Rights and Responsibilities under the Texas Workers' Compensation Act

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Notice to new Employees: You must give each new employee at the time of hire a written notice that includes the information in the posted notices. The written notice must also tell new employees that they have the right to choose not to be covered by your workers' compensation policy. Employees have 5 days from the date they begin employment to notify you in writing if they do not want to be covered by your policy. The written notice to new employee must be in wording adopted by the Division. If you do not provide this notice to new employees, you could be subject to a penalty up to \$500 per occurrence.

For Copies of the required notices, call 512-804-4333, or write DWC Forms, MS-91, 7551 Metro Center Drive, Suite 100, Austin, TX 78744-1609.

4) Other Responsibilities

Drug Policy, if required: If you have 15 or more employees, you must have a policy to eliminate drug abuse in your workplace. You must give a copy of the policy to each employee.

For a free copy of the Division's Drug-Free Workplace Resource Guide, which includes information on development of a drug-free workplace policy, call 512-804-4624 or write DWC Health and Safety Resource Center, MS-25, 7551 Metro Center Drive, Suite 100, Austin, TX 78744-1609. The Drug-Free Workplace Resource Center Publications/Videos at our website (www.tdi.state.tx.us).

Accident Prevention Plan, if required: If you are identified by the Division as a hazardous employer or are identified by the Texas Mutual Insurance Company to participate in an injury prevention program, you must adopt an accident prevention plan developed by an approved consultant who may be from the Division or your insurance carrier, or may be a Division-approved provider. The initial consultation must occur within 30 days of the date you receive notice that you have been identified to participate in an accident prevention program.

ADMINISTRATIVE AND CRIMINAL VIOLATIONS

Fraud: You could be subject to a penalty up to \$5,000 and possibly referred for criminal fraud investigation if you knowingly or intentionally commit an act to deny workers' compensation benefits to someone legally entitled to receive benefits. You also could be liable for past payments and interest.

Charge Backs: You may not charge your workers' compensation premiums back to your employees either directly or indirectly. If you charge premiums back to employees, you could be subject to a penalty up to \$1,000 per violation. Your employees may also recover damages in court.

Misrepresentation of Payroll: You could be subject to a penalty up to \$5,000 per occurrence if you intentionally misrepresent your payroll or provide false information to obtain lower insurance premiums. You could also be held liable for missed premiums.

Discrimination Against Employees: Texas law prohibits discharging or discriminating against an employee because the employee in good faith filed a workers' compensation claim, hired an attorney, testified, or will testify in a workers' compensation proceeding.

Return to Work Program for Employers

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By providing meaningful, productive work for your injured workers during his or her recovery, you can reduce your workers' compensations costs significantly.

Because your experienced and trained employees are continuing to do productive work for your company, you will be paying earned wages instead of workers' compensation income benefits. Most often, being away from work is medically unnecessary and can result in additional complications to the injury, delaying recovery and increasing the negative impact of the injury on injured workers and their families.

Talk to your insurance adjuster as soon as an injured worker begins to lose time from work.

Your insurance carrier can provide return to work coordination services to help you reduce unnecessary lost time and help your employees to continue to work during their recovery. Your adjuster also can help you understand the functional capabilities of your employees and help you work with health care providers as your employees recover.

It is important to help an injured worker focus on recovery.

Returning to a normal routine, including employment, as soon as possible is an integral part of the recovery process. Studies have shown that being off work longer than absolutely necessary can cause additional physical complications that could not only delay recovery but also increase your workers' compensation costs. Additional studies have shown that injured workers who continue to work require less medical care; therefore, you not only be paying lower medical costs for these employees but also over time should have lower workers' compensation premiums.

If an injured worker is unable to perform his or her regular duties, consider allowing the employees to perform a different job, within their capabilities, that is still important to the daily operations of your organization.

Modified or alternate assignments that are transitional in nature make it possible for the injured workers to stay engaged as productive members of the workplace. Consider modifying injured workers' work hours or allowing the injured workers to work at a slower pace. By remaining active in your employee's recovery process you not only help your business but you also increase the likelihood that your employees will continue to be productive members of the workforce.

DWC provides information to help employers with successful stay at work/return to work efforts. The information is available on the DWC website at http://www.tdi.state.tx.us/ or the information can be mailed to you. To request a copy of the Employers Resource Guide, or for specific assistance or questions, please call DWC at (512) 804-4804, or e-mail rttp://www.tdi.state.tx.us/.

You also can contact your local DWC Field Office. It is essential that all system participants work together to help injured workers stay motivated in the recovery and return to work process.

Thank you in advance for your interest and cooperation in this process.

Karl Guidry

From: Scarpa, Kimi - OSHA [Scarpa.Kimi@dol.gov]

Sent: Wednesday, December 17, 2008 3:33 PM

To: Karl Guidry

Subject: OSHA email address

Kimi

17625 El Camino Real, Suite 400 Houston, TX 77058 281-286-0583

Fax: 281-286-6352

OSHA's Mission: To assure safe and healthful working conditions for working men and women. <u>HSAO's VISION</u>: Utilizing the talents and skills of OSHA's finest, we will execute "The Missions" professionally, effectively, efficiently and with respect toward one another and our constituents. To meet this vision we will use the values set forth in TEAM CORE.

NOTICE:

This e-mail message and any attachments to it may contain confidential information. The information contained in this transmission is intended solely for the use of the individual(s) or entities to which the e-mail is addressed. If you are not the intended recipient, or an employee or agent responsible for delivering this message to the intended recipient, you are hereby notified that you are prohibited from reviewing, retransmitting, converting to hard copy, copying, disseminating, or otherwise using in any manner this e-mail or any attachments to it. If you have received this message in error, please notify the sender by replying to this message and delete it from your computer.

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January 29, 2009

Claim & Information Services
P.O. Box 12029
Austin, TX 78711-2029
1-800-859-5995 (512) 224-3800
Fax (512) 224-3889

C E S ENVIRONMENTAL SERVI ATTN: KARL GUIDRY 4904 GRIGGS RD HOUSTON, TX 77021-3208

Re:

Claim #:

Employee:

Soc. Sec.:

Employer:

yer: CESENVIRONMENTAL SERVI

JOEY SUTTER

401-08-2362

Date of Injury: 12/18/2008 DWC#: 09169549

Dear Karl,

Thank you for submitting the attached Wage Statement. We have reviewed the form and have found information that must be changed to meet the requirements of the Division of Workers' Compensation. Please make the following corrections:

- 1) Period No. 13 includes the date of injury; please provide wages by adjusting the reporting period backward so the date of injury is not included.
- 2) Period No. 7 reports only 39.13 hours worked. Why the decrease in hours for this week?
- 3) The no. of hours worked appear to reflect more than 40 hours a week except of period no. 7. Hours worked over 40 hours are they overtime hours?
- 4) Under Non-Pecuinary wage information, you report that pay period no. 12 and no. 13 employer paid health insurance. Did he not have this benefit prior to that time?
- 5) Under Non-Pecuinary wage information, the employer provided clothing/uniforms but no specific value was given. Please provide a specific value for this benefits for each reported period this benefit was provided prior to the injury of 12/18/08.

Please note that the salary history cannot include, nor go beyond, the date of injury. Thank you for your prompt attention to this matter. If you have any questions, please call me at 1-800-859-5995 ext. 7291.

Sincerely,

Karin T. Crouse

CAT WORKERS' COMP SPEC II

Enclosure: Wage Statement

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| | VEDIC MACE | | NT (DWC Form | |
| | | | . • | • |
| The Texas Workers' Compensation Act and Worsquire an employer to provide an Employer's Wat compensation insurance carrier (carrier) and the representative, if any. The purpose of the form is wage information to the carrier for calculating the ewage (AWW) to establish benefits due to the employer. | se Statement to its workers' claimant or the claimant's to provide the employee's mployee's Average Weekly | manner prescribed by (| ely file a complete wage su ne Olvisian. ent shall be filed ("filed" m d the claimant's representati | eans received) with the |
| The AWW is based on the wages the employed immediately preceding the date of injury (or the earned if the employes did not work the full 13-weer all forms of remuneration payable to an employincluding fringe benefits. To simplify filing, employing the property of the employed including fringe benefits. | e earned in the 13 weeks wage a similar employee k period). "Wages" include yee for personal services, | (B) the date the endincome benefits; (C) the date of the endine of the e | eighth day of disability; mployer is notified that the mployee's death as a result t nt shall also be filed with th | of a compensable injury. |
| monthly, blweekly, or weekly manner as discussed | below. | days of receiving a requ | est from the Division (Only V | Vhen Requested). |
| NOTE - An employer who fails without good cause wage statement as required by the Taxas Workers Labor Code, Section 408.063(c) and Worker's Conbe assessed an administrative penalty. | Compensation Act, Texas | end the employee's the employer discontinued of the date | , | nin seven days if any nent changes (such as if y wage that was initially |
| | | All applicable DV | VC rules can be found at w | ww.tdi.btate.pt.us |
| EMPLOYEE AND EMPLOYER INFO Employee's Name (Last, First, M.I.): | RMATION | Employer's Business No | ime: | |
| Sutter, Joey | | CES Environn | nental Services | |
| Employee's Malling Address (Street or P.O. Box): (b) (4) | | Employer's Malling Add 4904 Griggs Ro | reas (Street or P.O. Box): | |
| City: State: | 7IP Code: | City: | | ZIP Code: |
| b) (4) | | Houston | TX | 77021 |
| (b) (4) | • | 76-0592985 | r. | |
| Date of Inj (b) (4) Date of Inj | | Name and Phone # of P | erson Providing Wage Inform | nation: |
| (b) (4) 12/18/3 | | KARL A. GUA | dry 832-287- | 0862 |
| The employee returned to work on without restriction. OR with restrictions and is earning wages of week/month (circle one). NOTE - Rule 120.3 requires the employer file thinjury (DWC FORM-8) to report changes in We Earnings. | and is working: of \$per e Supplemental Report of | compiles with the Texa and the listed wages in (earned in) the 13 week and I understand the | HAT this wags statement is a Workers' Compensation A clude all pecuniary and nongs prior to the date of injury (it making a misrepresental commentation result in fines | tet and applicable rules, secuniary wages paid for as described on page 2) tion about a workers' |
| EMPLOYMENT STATUS AT TIME C | F INJURY (Check A | di That Apply) | | , |
| ☐ Full-time: employee who regularly works at least 30 hours per week and whose schedule is comparable to other employees of the company end/or other employees in the same business or vicinity who are considered full-time. ☐ Seasonal: employee who as regular course of conduct engages in seasonal or cyclical employment that may or may not be agricultural in nature and that does not continue throughout the year. | Part-time: Regular employee whose work period preceding the inju worked part-time during to Part-time: Not Regular employee whose work pariod preceding the injuitime work during that period preceding the injuiting work during that period preceding the injuiting work during that period preceding the injuiting which who work during the injuiting th | r Course of Conduct history for the 12-month in shows the person only hat period. Liar Course of Conduct history for the 12-month by shows part-time and fulled who is learning a skilled at expansion counter the | and not emancipated action who is also en student: Click Student: employee atudy in high achool, cold higher aducation or technical Trainse: employee | by marriage or judicial apprentice, trainee or acrolled in a course of lege or other institute of inical training. Undergoing systematic in some art, trade or its apprentice of inical training. |
| SAME OR SIMILAR EMPLOYEE? | | | | |
| | | If the employee was not | employed for 13 continuous | weeks before the date |
| The wage information on this form is for: | Employee (NOTE - II | of injury, report the way | employed for 13 continuous jes of an employee who ha able to the injured employe | e training, experience, 🎙 |

requested by the Division, the whose wages were provided.)

employee exists, report the limited available wages serned by the injured employee prior to the injury.

NOTE TO INJURED EMPLOYEE - If you were injured on or after 7/1/02, and had employment with more than one employer on the date of injury, you can provide your insurence carrier with wage information from your other employment for the carrier to include in your AWW and this may affect your benefits. Contact your carrier for additional information or call the Division at (800) 252-7031. You can also read rule 122.5 at www.tdi.state.tc.us/wc/rules/.

DWC FORM-003 Rev. 10/05

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JAN-29-2009

08:23

CES ENVIROMENTAL

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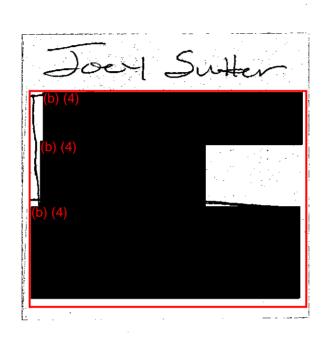
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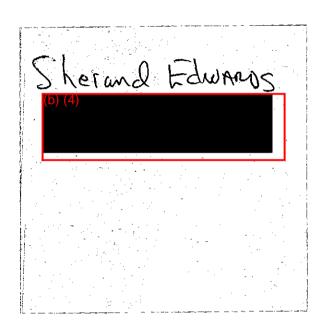
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Patriot Security EOC Proudest <u>Employee Owned Company</u> In <u>TEXAS!</u>

INCIDENT REPORT

| DATE: | TIME: AM. |
|---|---|
| 19-18-08 POST: Ex. Beatmont Enterprise CES | LOCATION, Ex. 2 nd , Floor |
| SECURITY OFFICERS NAME (PRINT): LAUREL L. MECALISOIV | POLICE DEPARTMENT: Ex. Beaumont PD |
| WITNESS: | AMBULANCE: Ex. Priority One |
| WITNESS: | FIRE DEPARTMENT: Ex. Beaumont FD PLI BUTUIT |

PRINT INCIDENT DETAILS IN ALL CAPITAL LETTERS
COMPLETE INCIDENT DRAWING ON BACK

| PT APPROX 2:03 I WEARD IS CALL FOR PLEUP. PERSON |
|---|
| CALLING FOR HISIP WAS SUZI MOCH CES EMPLOYED DUTOP |
| OF TRAILER TANK \$ 267 WITH JORY SUTTEN CES EMPLOYER |
| JOBY SUTTEN WAS 1785SED-OUT ONTOP OF TANK |
| I RAN TO TANK FROM SCALE BUIDING CALLING ON |
| MADIO FOR HELD. BROD WOOD GES ENDLOYER BUSGIES |
| ANSWERLD CALL FOR HIELP. BURIUNG DI SITE WITH-IN |
| A MIN. OFFICE MONDERN K. REESE COLLED 911 DE |
| At APPROX - 9:04 PM - OF APROXY: 9:20 PART |
| ATTHUR F/O BRRIUGO. S/O SAMES ON SITE TO |
| ASSIST. COULDS OFFICE TO REPORT. PROBLEW. BJ APPROX |
| D' BU STAT CARE AMBUCAUCE ARRIVED ON SITE. |
| PORT ANTHUR FID AND CES EMPLOYERS HELP BRING |
| JOHN SUTTEL OFF TOP OF TOUR 2:38 STOT CARE |
| AMBUCANCE LAST SITE WITH JOEY SUTTEN ON BOARD |
| PLANT MANAGEN KAL MYDERSON & OPENATION SUPER USON |
| BRIAN WEATHERS LOTIFIED BY DPPROX 2:15 BS THEY RETURNED |
| FROM LUNCH |

Security Officer's Signature:

Employee # 1006

Confidential and Proprietary Patriot Security EOC

Proudest Employee Owned Company In TEXAS!

EPAHO042001513

AND THE SWA



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ExonMobil

MATERIAL SAFETY DATA BULLETIN

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PAGE 1 OF 8

497

MCP 1397

1. PRODUCT AND COMPANY IDENTIFICATION

PRODUCT NAME: MCP 1397
SUPPLIER: EXXONMOBIL CHEMICAL COMPANY
SYNTHETICS DIVISION
2195 ROUTE 27
EDISON, NJ 08818

24 - Hour Emergency (call collect): 609-737-4411
Product and MSDS Information: 732-321-6048
CHEMIREC: 800-424-9300 202-483-7616

2. COMPOSITION/INFORMATION ON INGREDIENTS

CHEMICAL NAMES AND SYNONYMS: SULFURIZED ISOBUTYLENE

INGREDIENTS CONSIDERED HAZARDOUS TO HEALTH:

This product is not formulated to contain ingredients which have exposure limits established by U.S. agencies. It is not hazardous to health as defined by the European Union Dangerous Substances/Preparations Directives. See Section 15 for a regulatory analysis of the ingredients.

OTHER POTENTIALLY MAZARDOUS INGREDIENTS:

SULFURIZED ALKENE 100

See Section 15 for European Label Information.

See Section 8 for exposure limits (if applicable).

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MATERIAL SAFETY DATA BULLETIN

20APR1999

HCP 1397

PAGE 2 OF 8

3. HAZARDS IDENTIFICATION

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US OSHA HAZARD COMMUNICATION STANDARD: Product assessed in accordance with OSHA 29 CFR 1910.1200 and determined to be hazardous.

EFFECTS OF OVEREXPOSURE: Respiratory irritation, dizziness, nausea, loss of consciousness. Prolonged repeated skin contact with low viscosity materials may defat the skin resulting in possible irritation and dermatitis.

EMERGENCY RESPONSE DATA: Amber Liquid. Material is combustible.

Exposure to fire can generate highly toxic fumes. DOT ERG No.:

4. FIRST AID MEASURES

128 . SEC: 2

EYE CONTACT: Flush thoroughly with water. If irritation occurs, call a physician.

a physician.

SKIN COMTACT: Wash contact areas with soap and water. Remove contaminated clothing. Launder contaminated clothing before reuse.

INHALATION: Remove from further exposure. If respiratory irritation, dizziness, nausea, or unconsciousness occurs, seek immediate medical assistance and call a physician. If breathing has stopped, use mouth to mouth resuscitation.
INGESTION: Do not induce vomiting. Get medical assistance.

INGESTION: Do not induce vomiting. Get medical assistance.

NOTE TO PHYSICIANS: Material if aspirated into the lungs may cause chemical pneumonitis. Treat appropriately.

5. FIRE-FIGHTING MEASURES

EXTINGUISHING MEDIA: Carbon dioxide, foam, dry chemical and water fog. SPECIAL FIRE FIGHTING PROCEDURES: Use water to keep fire exposed containers cool. If a leak or spill has not ignited, use water spray to disperse the vapors and to protect personnel attempting to stop leak. Water spray may be used to flush spills away from exposures. Prevent runoff from fire control or dilution from entering streams, sewers, or drinking water supply.

SPECIAL PROTECTIVE EQUIPMENT: For fires in enclosed areas, fire fighters must use self-contained breathing apparatus.

UNUSUAL FIRE AND EXPLOSION HAZARDS: Material is combustible. Exposure to fire can generate highly toxic funes. Flash Point C(F): 81 (178) (ASTM D-93). Flammable limits - LEL: NE, UEL: NE.

NFFA HAZARD ID: Health: 2, Flammability: 2, Reactivity: 0

HAZARDOUS DECOMPOSITION PRODUCTS: Carbon monoxide. Sulfur oxides.

Date Printed Thursday, March 07, 2002

EXonMobil

MATERIAL SAFETY DATA BULLETIN

20APR1999

MCP 1397

PAGE 3 OF 6

6. ACCIDENTAL RELEASE MEASURES

NOTIFICATION PROCEDURES: Report spills as required to appropriate authorities. U. S. Coast Guard regulations require immediate reporting of spills that could reach any waterway including intermittent dry creeks. Report spill to Coast Guard toll free number (800) 424-8802. In case of accident or road spill notify

CHEMTREC (800) 424-9300.
PROCEDURES IF MATERIAL IS RELEASED OR SPILLED: Eliminate all ignition sources. Adsorb on fire retardant treated sawdust, diatomaceous earth, etc. Shovel up with spark-resistant shovel and remove to appropriate waste disposal facility in accordance with current applicable laws and regulations.

ENVIRONMENTAL PRECAUTIONS: Prevent spills from entering storm sewers or drains and contact with soil. PERSONAL PRECAUTIONS: See Section 6

7. HANDLING AND STORAGE

HANDLING: Use in well ventilated area away from all ignition sources. Avoid sparking conditions. Ground and bond all transfer equipment.

STORAGE: Store in a cool area away from all ignition sources. Store in a cool area.

8. EXPOSURE CONTROLS/PERSONAL PROTECTION

VENTILATION: Use local exhaust over heating operations. Use in Well ventilated area. Ventilation desirable and equipment should be explosion proof.

RESPIRATORY PROTECTION: Use appropriate respiratory protective

equipment during heating operations.

EYE PROTECTION: Normal industrial eye protection practices should be

employed.

SKIN PROTECTION: If prolonged or repeated skin contact is likely, impervious gloves should be worn. Good personal hygiene practices should always be followed.

EXPOSURE LIMITS: This product does not contain any components which have recognized exposure limits.

9. PHYSICAL AND CHEMICAL PROPERTIES

Typical physical properties are given below. Consult Product Data Sheet for specific details.

APPEARANCE: Liquid GOLOR: Amber ODOR: Mercaptan ODOR THRESHOLD-ppm: NE

pH: NA

(Section continued next page)

EXonMobil

MATERIAL SAFETY DATA BULLETIN

20APR1999

MCP 1397

PAGE 4 OF 8

BOILING POINT C(F): NE
MELTING POINT C(F): NA
FLASH POINT C(F): \$1(178) (ASTM D-93)
FLAMMABILITY: NE
AUTO FLAMMABILITY: NE
EXPLOSIVE PROPERTIES: NA
OXIDIZING PROPERTIES: NA
VAPOR PRESSURE-mmHg 20 C: NE
VAPOR DENSITY: NE
EVAPORATION RATE: NE
EVAPORATION RATE: NE
RELATIVE DENSITY, 15/4 C: 1.03
SOLUBILITY IN WATER: Negligible
PARTITION COEFFICIENT: NE
VISCOSITY AT 40 C, cst: 5.3
VISCOSITY AT 100 C, cst: 1.7
POUR POINT C(F): < -64(-83)
FREEZING POINT C(F): NE
VOLATILE ORGANIC COMPOUND: NE
NA=NOT APPLICABLE NE=NOT ESTABLISHED D=DECOMPOSES

FOR FURTHER TECHNICAL INFORMATION, CONTACT YOUR MARKETING REPRESENTATIVE

10. STABILITY AND REACTIVITY

STABILITY (THERMAL, LIGHT, ETC.): Stable.
CONDITIONS TO AVOID: Heat, sparks, flame and build up of static electricity.
INCOMPATIBILITY (MATERIALS TO AVOID): Strong oxidizers,
HAZARDOUS DECOMPOSITION PRODUCTS: Carbon monoxide. Sulfur oxides.
HAZARDOUS POLYMERIZATION: Will not occur.

11. TOXICOLOGICAL DATA

ORAL TOXICITY (RATS): Practically non-toxic.

DERMAL TOXICITY (RABBITS): Practically non-toxic (LD50: greater than 2000 mg/kg). ---Based on testing of similar products and/or the components.

INHALATION TOXICITY (RATS): Practically non-toxic (LC50: greater than 5 mg/l). ---Based on testing of similar products and/or the components.

EYE IRRITATION (RABBITS): Practically non-irritating. Eye irritation scores: 6.0 at 24 hours, 3.3 at 48 hours, 2.3 at 72 hours

SKIN IRRITATION (RABBITS): Practically non-irritating. Primary irritation score: 0.8/8

OTHER ACUTE TOXICITY DATA: ***DOT skin corrosivity (4 hours):

Negative ***

---GENETIC TOXICOLOGY (SUMMARY)--***Mouse Lymphoma (L5178Y/TK+/-) Assay: Positive. ***Negative Ames
Test.

EXonMobil

MATERIAL SAFETY DATA BULLETIN

20APR1999

MCP 1397

PAGE 5 OF 8

12. ECOLOGICAL INFORMATION

ENVIRONMENTAL FATE AND EFFECTS: After 28 days, 3.3% of this material was converted to CO2 in the OECD 301B (Modified Sturm) test.

13. DISPOSAL CONSIDERATIONS

WASTE DISPOSAL: Product is suitable for burning in an enclosed, controlled burner for fuel value or disposal by supervised incineration. Such burning may be limited pursuant to the Resource Conservation and Recovery Act. In addition, the product is suitable for processing by an approved recycling facility or can be disposed of at an appropriate government waste disposal Use of these methods is subject to user compliance with applicable laws and regulations and consideration of product characteristics at time of disposal.

RCRA INFORMATION: The unused product, in our opinion, is not specifically listed by the EPA as a hazardous waste (40 CFR, Part 2610), nor is it formulated to contain materials which are listed hazardous wastes. It does not exhibit the hazardous characteristics of ignitability, corrosivity, or reactivity and is not formulated with contaminants as determined by the Toxicity Characteristic Leaching Procedure (TCLP). However, used product may be requirated may be regulated.

14. TRANSPORT INFORMATION

USA DOT:

SHIPPING NAME:

Combustible Liquid, n.o.s. (contains

SULFURIZED ISOBUTYLENE)

HAZARD CLASS & DIV:

COMBUSTIBLE LIQUID

ID NUMBER:

EPRIAN 128

ERG NUMBER: PACKING GROUP:

PG III

STCC:

NΕ

DANGEROUS WHEN WET: POISON:

No

LABEL(s):

PLACARD(s):

NA Combustible

PRODUCT RO: MARPOL III STATUS: NA NA.

In accordance with 49 CFR 173.150(f)(2), non-bulk quantities of this material (<119 gallons per container) may be shipped as non regulated - for USA domestic shipments.

RID/ADR: NOT REGULATED BY RID/ADR.

IMO: NOT REGULATED BY IMO.

(Section continued next page)

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ExonMobil

MATERIAL SAFETY DATA BULLETIN

20APR1999

MCP 1397

PAGE 6 OF 8

IATA: NOT REGULATED BY IATA.

15. REGULATORY INFORMATION

Governmental Inventory Status: All components comply with TSCA, EINECS/ELINCS, AICS, METI, and DSL.

EU Labeling:

Symbol: Not applicable.

Risk Phrase(s): Not applicable.

Safety Phrase(s): S24-62.

Avoid contact with skin. If swallowed, do not induce vomiting: seek medical advice immediately and show this container or label.

Contains: Sulfurized Isobutylene.

U.S. Superfund Amendments and Reauthorization Act (SARA) Title III: This product contains no "EXTREMELY HAZARDOUS SUBSTANCES".

SARA (311/312) REPORTABLE HAZARD CATEGORIES: FIRE CHRONIC

This product contains no chemicals subject to the supplier notification requirements of SARA (313) toxic release program.

The following product ingredients are cited on the lists below: CHEMICAL NAME CAS NUMBER LIST CITATIONS

*** NO REPORTABLE INGREDIENTS ***

1=ACGIH ALL 6=IARC 1 11=TSCA 4 16=CA P65 CARC 21=LA RTK 2=ACGIH A1 7=IARC 2A 12=TSCA 5a2 17=CA P65 REPRO 22=M1 293 3=ACGIH A2 8=IARC 2B 13=TSCA 5e 18=CA RTK 23=MN RTK 4=NTP CARC 9=OSHA CARC 14=TSCA 6 19=FL RTK 24=NJ RTK 5-NTP SUS 10=OSHA 2 15=TSCA 12b 20=IL RTK 25=PA RTK 26=RI RTK

Code key: CARC=Carcinogen; SUS=Suspected Cardinogen; REPRO=Reproductive

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MATERIAL SAFETY DATA BULLETIN

20APR1999

MCP 1397

PAGE 7 OF 8

16. OTHER INFORMATION

Precautionary Label Text:

CONTAINS SULFURIZED HYDROCARBONS

CAUTION!

COMBUSTIBLE LIQUID AND VAPOR. MAY CAUSE NOSE, THROAT AND LUNG IRRITATION, DIZZINESS, NAUSEA, LOSS OF CONSCIOUSNESS. LOW VISCOSITY MATERIAL—IF SWALLOWED, MAY BE ASPIRATED AND CAN CAUSE SERIOUS OR FATAL LUNG DAMAGE.

PROLONGED, REPEATED SKIN CONTACT MAY CAUSE IRRITATION.

Keep away from heat and flame. Avoid contact with skin or clothing. Avoid breathing vapor. Keep container closed. Use with adequate ventilation.

FIRST AID: If inhaled, remove to fresh air. If not breathing, give artificial respiration, preferably mouth-to-mouth. If breathing is difficult, give oxygen. Call a physician immediately. In case of contact, wash skin with soap and water. Remove contaminated clothing. Call a physician if irritation persists. Wash clothing before reuse. If swallowed, seek immediate medical attention. Do not induce vomiting. Only induce vomiting at the instruction of a physician.

For industrial use only. Not intended or suitable for use in or around a household or dwelling.

Empty container may contain product residue, including flammable or explosive vapors. Do not cut, puncture, or weld on or near container. All label warnings and precautions must be observed until container has been thoroughly cleaned or destroyed.

Refer to product Material Safety Data Bulletin for further safety and health information.

USE: EXTREME PRESSURE ADDITIVE

NOTE: PRODUCTS OF EXXON MOBIL CORPORATION AND ITS AFFILIATED COMPANIES ARE NOT FORMULATED TO CONTAIN PCBS.

ingredient

CAS NUMBER

1-PROPENE, 2-METHYL-, SULFURIZED

68511-50-2

For Internal Use Only: MHC: 0 1* 0* 0 1, MPPEC: C, TRN: 6013973-00, REQ: CHEMICAL PRODUCTS, SAFE USE: C

EHS Approval Date: 20APR1999

(Section continued next page)



Patriot Security EOC Proudest Employee Owned Company In TEXAS!

INCIDENT REPORT

| DATE: | TIME. AM |
|---------------------------------|-------------------------------------|
| 12-18-08 | 2/80 PM |
| POST: Ex. Beaumont Enterprise | LOCATION: Ex. 2 rd Floor |
| CES | YARD |
| SECURITY OFFICERS NAME (PRINT): | POLICE DEPARTMENT: Ex. Beaumont PD |
| LAUREL L. ATCALISAIN | |
| WITNESS: | AMBULANCE: Ex Priority One |
| | STAT CONS |
| WITNESS: | FIRE DEPARTMENT: Ex. Beaumont FD |
| | PORT BRITAUN |

PRINT INCIDENT DETAILS IN ALL CAPITAL LETTERS COMPLETE INCIDENT DRAWING ON BACK

| BY APPROX 2:03 I MEDRO B CALL FOR HELP. PLISON CHUNK FOR HELP WAS SUZI MOCK CES EMPLOYED ON JOP OF TRAILER TANK 267 WITH JOFY SUTTEN CAS EMPLOYED JOEY SUTTEN WAS PRESENTED ON JOHN OF TANK I RAN TO TANK FROM SCALE BUILDING CALLING ON MADIO NOR MELP. BRAD WOOD CES EMPLOYED BUSINESS. ANSWERD CALL FOR HELP. BURRING AT SITE WITH-IN A MIN. DEFICE MANAGEM K. RELEST COLLED 911 APP AT APPROX - 0:04 PM. AT APRAGE: 0:20 PART ANTHOR FOD ARRIVED. S/O JAMES ON SITE TO ASSIST. CALLE AMBRICANCE DEPLOYED ON SITE. PONT ANTHUM F/D AND CES EMPLOYEES HELP BRING JOEY SUTTEN AFF TOP TANK. 2:38 STAT CARE AMBULANCE LEFT SITE WITH JOEN SUTTEN ON BOARD FRANT MANAGEM KALL ANDERSON & OPERATION SUPER USON BRIAN WEATHERS NOTHING AT APPROX 2:15 AS THEY DETAINED | |
|--|--|
| SEY SUTTEN WAS PASSED-OUT SUTEN CAS EMPLOYED JOBY SUTTEN WAS PASSED-OUT SUTEN OF TANK J RAN TO JANK FROM SCALE BUNDING CALLING ON RADIO KOR MENT. BRAD WOOD CES EMPLOYEE PASSENTO ANSWERDD CAN FOR HISTER MARRIUNG AT SITE WITH-IN A MIN. OFFICE MONDESON K. REESE CONSED 911 ATT ATTHUR F/D ARRIVED. S/O JANES ON SITE TO ASSIST. CANDO OFFICE TO RAPORT. PROBLEM. AT APPROX 3: 34 STAT CARE AMBURANCE ARRIVED ON SITE. POST ANSIGN F/D AND CES EMPLOYEES HELP BRING DOLY SUTTEN AFF TOP OF TANK. 2:38 STAT CARE AMBURANCE LEFT SITE WITH JOEN SUTTEN ON BOADS FRANT MARRIEDS NOTIFIED AT APPROX SUPER USOR | BY APPROX 2:03 I WEARD B CALL FOR HIELP. PERSON |
| JOBY SUTTEN WAS PASSED-OUT ONTO JONE TANK J RAN TO JANK FROM SCALE BUILDING CALLING ON RADIO FOR HELD. BRAD WOOD CES EMPLOYEE BUSENESS BUSWERED CAN FOR HELP. BURING MI SITE WITH-IN A MIN. OFFICE MANAGEN K. REESE COLLED 911 DEF AT APPROX - 9:04 PM. OF BRADGY: 9:00 PART ATTHUR F/D ARRIVED. S/O JANES ON SITE TO ASSIST. CALLED OFFICE TO REPORT PROBLEW. BY APPROX O: 34 STAT CARE AMBUCANCE ARRIVED ON SITE. PONT ANTHUM F/D AND CES EMPLOYEES MEIP BRING JOEY SUTTEN AFF TOP OF TANK. 9:38 STAT CARE BANGULANCE LEFT SITE WITH JOEY SUTTEN ON BOARD PRANT MANAGEM KAL ANDERSON & OPERATION SUPERVISOR | CHLUNG FOR JIBLE WAS BUZI MOCH CES EMPLOYEE ON TOP |
| JOBY SUTTEN WAS PASSED-OUT ONTO JONE TANK J RAN TO JANK FROM SCALE BUILDING CALLING ON RADIO FOR HELD. BRAD WOOD CES EMPLOYEE BUSENESS BUSWERED CAN FOR HELP. BURING MI SITE WITH-IN A MIN. OFFICE MANAGEN K. REESE COLLED 911 DEF AT APPROX - 9:04 PM. OF BRADGY: 9:00 PART ATTHUR F/D ARRIVED. S/O JANES ON SITE TO ASSIST. CALLED OFFICE TO REPORT PROBLEW. BY APPROX O: 34 STAT CARE AMBUCANCE ARRIVED ON SITE. PONT ANTHUM F/D AND CES EMPLOYEES MEIP BRING JOEY SUTTEN AFF TOP OF TANK. 9:38 STAT CARE BANGULANCE LEFT SITE WITH JOEY SUTTEN ON BOARD PRANT MANAGEM KAL ANDERSON & OPERATION SUPERVISOR | |
| ABDIO FOR HEIR- BRAD WOOD CES ENDIOYER BUSENESS BUSWERED CALL FOR HISTP. BURIUM BY SITE WITH-IN B HIN. OFFICE MANDEN K. REESE COLLED 911 BY BY BPPROX - 0:04 PM - OF BRADON: 0:20 PART BUTHUR F/D BRUINDD. S/O JAMES ON SITE TO BESIST, COLLAGO OFFICE TO REPORT. PROBLEM. BY BPPROX O: QU STAT CARE AMBUCANCE ARRIVAD ON SITE. PONT ANTHUR F/D AND CES EMPLOYEES HEIP BRING JOEY SUTTEN OFF TOP OF TANK. 0:38 STAT CARE BUBULANCE LEFT SITE WITH JOEY SUTTEN ON BOARD FLANT MANAGER KAL BADERSON & OPERATION SUPER DISON BRIAN WEATHERS NOTIFIED AT OPPROX 2:15 BS THEY DETAINED | |
| ANSWERED CAN FOR FIELD. BIRIVING BJ BITE WITH-IN A MIN. OFFICE MANAGEN K. REESE CONED 911 BEE AT APPROX - 9:04 PM - AT BRAGOY: 9:20 PART ATTHUR F/D ARRIVED. S/O JANES ON SIJE TO ASSIST, CANBO OFFICE TO REPORT. PROBLEM. BT APPROX 8: AU STAT CARE AMBURANCE ARRIVED ON SIJE. PONT ANTHUR F/D AND CES EMPLOYEES HELP BRING JOLY SUTTEN AFF TOP OF TANK. 9:38 STAT CARE AMBURANCE LEFT SIJE WITH JOLY SUTTEN ON BOARD PRANT MANAGEN KAL ANDERSON & OPERATION SUPER USOR | I RAN TO TOUR FROM SCALE BULDING CALLING ON |
| ANSWERED CAN FOR FIELD. BIRIVING BJ BITE WITH-IN A MIN. OFFICE MANAGEN K. REESE CONED 911 BEE AT APPROX - 9:04 PM - AT BRAGOY: 9:20 PART ATTHUR F/D ARRIVED. S/O JANES ON SIJE TO ASSIST, CANBO OFFICE TO REPORT. PROBLEM. BT APPROX 8: AU STAT CARE AMBURANCE ARRIVED ON SIJE. PONT ANTHUR F/D AND CES EMPLOYEES HELP BRING JOLY SUTTEN AFF TOP OF TANK. 9:38 STAT CARE AMBURANCE LEFT SIJE WITH JOLY SUTTEN ON BOARD PRANT MANAGEN KAL ANDERSON & OPERATION SUPER USOR | RADIO FOR HELP. BRED WOOD CES ENDLOYER BUSINES |
| B MIN. OFFICE MONDESS K. PEESE COLLED 911 DEP OF APPROX - 9:04 PM - OF APPROX: 9:20 PORT ATHUR F/D ARRIVED. : 5/0 JONES ON SITE FO ASSIST. COLLED OFFICE TO REPORT. PROBLEW. BY APPROX 9: 34 STAT CORE AMBUCANCE ARRIVED ON SITE. PORT ANTIUM F/D AND CES EMPLOYEES HELP BRING JOLY SUTTEN OFF TOP OF TANK. 2:38 STAT CARE AMBUCANCE LEFT SITE WITH JOEN SUTTEN ON BOOKD PRANT MANAGEM KAL ANDERSON & OPERATION SUPERVISOR BRIAN WEATHERS NOTIFIED AT APPROX 2:15 AS THEY RETURNED | |
| AT APPROX - 9:04 PM - OF BREROY: 9:20 PART ATTHUR F/D ARRIVED . S/O JONES ON SITE TO ASSIST. COURS OFFICE TO REPORT. PROBLEW. BY APPROX 9: 34 STAT CARE AMBUCANCE ARRIVED ON SITE. PORT ANTHUM F/D AND CES EMPLOYEES HELP BRING JOLY SUTTEN AFF TOP OF TANK. 9:38 STAT CARE AMBUCANCE LEFT SITE WITH JOEY SUTTEN ON BOARD PLANT MANAGEM KAL ANDERSON & OPENATION SUPER DISON BRIAN WEATHERS NOTIFIED AT APPROX 9:15 AS THEY RETAINED | |
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| ASSIST, CALLED OFFICE TO REPORT. PROBLEW. BY BPPROX D: QUI STAT CARE AMBURANCE ARRIVED ON SITE. PORT ANTHUR F/D AND CES EMPLOYEES HEIP BRING JOEY SUTTEN OFF TOP OF TANK. 2:38 STAT CARE AMBURANCE LEFT SITE WITH JOEY SUTTEN ON BOARD PRANT MANAGER KAL ANDERSON & OPERATION SUPERVISOR BRINN WEATHERS NOTIFIED AT APPROX 2:15 AS THEY DETAILS. | ATTHUR F/D ARRIVED. 5/6 JOHES ON SITE TO |
| PORT ANTIUN F/D AND CES EMPLOYEES HELP BRING JOEY SUTTEN OFF TOP OF TANK. 2:38 STAT CARE AMBULANCE LEFT SITE WITH JOEY SUTTEN ON BOARD SHANT MANAGER KAL ANDERSON & OPERATION SUPER DISOR BRIAN WEATHERS NOTIFIED AT APPROX 2:15 AS THEY DETAINED | |
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| | PLANT MANAGER KAL ANDERSON & OPERATION SUPER USOR |
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Security Officer's Signature:

Employee # 1006

Confidential and Proprietary Patriot Security EOC

Proudest Employee Owned Company In TEXAS!



Patriot Security EOC Proudest <u>Employee Owned Company</u> In <u>TEXAS!</u>

INCIDENT REPORT

| DATE: 19-18-08 | TIME: AM |
|---|---|
| POST: Ex. Beaumont Enterprise CES | LOCATION: Ex. 2nd Floor |
| SECURITY OFFICERS NAME (PRINT): LAUREL L. HECHISON | POLICE DEPARTMENT: Ex. Beaumont PD |
| WITNESS: | AMBULANCE: Ex. Priority One STOT GOLDS |
| WITNESS: | FIRE DEPARTMENT: Ex. Beaumont FD POL BUTUIT |

PRINT INCIDENT DETAILS IN ALL CAPITAL LETTERS COMPLETE INCIDENT DRAWING ON BACK

| BY BPPROX 3:03 I WEARD B CALL FOR HIELP. PURSON |
|---|
| CALLING FOR HIGH WAS SUZI MOCH CES EMPLOYEE ON JOP |
| OF TRAILER TANK \$267 WITH JOEY SUTTEN CAS EMPLOYER |
| JOBY SUTTEN WAS PASSED-OUT OUTOR OF TANK |
| I RAN TO TOUR FROM SCALE BULDING CALLING ON |
| RADIO FOR MELP- BROD WOOD CES ENDLOYER BUSINES |
| ANSWERSD CALL FOR SIELP. BURIUNG AT SITE WITH-IN |
| A MIN. OFFICE MANDESA K. REESE COLLED 911 DE |
| OF APPROX - 9:04 PM. OF APROX: 9:20 PORT |
| ATTHUR F/O ARRIVED. :5/0 JAMES ON SITE TO |
| ASSIST. COULDO OFFICE TO REPORT. PROBLEW. BT OPPROV |
| D' QU STAT CARE AMBUCANCE BRRIVED ON SITE. |
| PORT BRITION F/D BUD CES EMPLOYEES HELP BRING |
| JOHN SUTTEN OFF TOP OF TANK 2:38 STAT CARE |
| BMBULONCE LEFT SITE WITH JOEY SUTTEN ON BOBBE |
| PLANT MANACAN KAL ANDERSON & OPENATION SUPER DISON |
| BRIAN WEATHERS NOTIFIED BY APPROX 2:15 BS THEY RETURNED |
| FROM LUNCH |
| TA-M ONNE PI |

Security Officer's Signature: Employee # 1006

Confidential and Proprietary Patriot Security EOC

Proudest Employee Owned Company In TEXAS!

HAN SW BAR

On 12-18-08 Ricky CAME into my office after the ambulance took Joey to the hospital. Ite asked me what had happened and if Joey had died. I gave him a brief statement of what had happened and that I did not know if Joey was alead. I could tall by Ricky's ale meanor that he were upset angry with what had happened with Joey and, I could tell he thought I was with holding information or giving him the "Company Line". I assured him that I truley did not know the status of Joey. The last thing I knew at that time was that the fire department said Joey had a pulse when he left in the ambulance.

Ricky then began to say, to the effect "It Joey is clear he was guitting That he was going to save his life and, every body else's life."

That I should ask Melton melton knows his people. That if something were to happen to Ricky that his people would take CES out."

I looked at Ricky with a blank look, Shrugged my shookders, and told him I don't know

Ricky then walked out of my office with an appearant attitude. Deter that evening I relayed what transpired in my office.

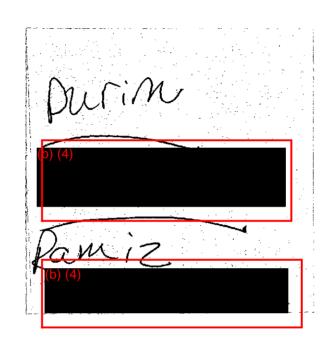
Cont.

Frieldy morning I called Ricky on his work phone asking him where he was end asked him if he was comming to Port Arther today. He told me "He sintheston that he washt going to the Port Arther"

He told me in a very oalm and unsure tone that he was in Houston and probably not comming out to Port Arther that day"

I told him "OK - Thanks and if he knew if Malton was comming or any body else, and he said he didn't know.

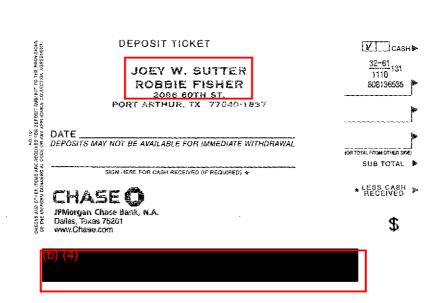
WILBNOWD R-23-08





| DEPOSIT TICKET JOEY W. SUTTER ROBBIE FISHER | 22-61 32-61 1110 808136635 ▶ |
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| DEPOSIT TICKET JOEY W. SUTTER ROBBIE FISHER 2096 SOTH ST. PORT ARTHUR, YX 77640-1837 DAYE DEPOSITS MAY NOT BE AVAILABLE FOR IMMEDIATE WITHDRAWAL SIGN HERE FOR CASH RECEIVED OF REQUIRED) * JPMorgan Chase Bank, N.A. Dallas, Texas 78261 JPMorgan Chase Bank, N.A. Dallas, Texas 78261 Standard Communication of the Communic | <u> </u> |
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| JPMorgan Chase Bank, N.A. Dallas, Texas 78201 www.Chase com | \$ |
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Application For Employment Solicitud de Empleo

We consider applications for all positions without regard to race, color, religion, creed, sex, national origin, disability, sexual orientation, citizenship status or any other legally protected status. Aceptamos solicitudes para todas las posiciones sin tomar en cuenta raza, color, religión, oredo, sexo, nacionalidad, incapacidad, orientación sexual, estado de ciudadanía, o cualquier otro estado protegido legalmente.

| (PLEASE PRINT/SIRVAS | SE ESCRIBIR | EN LETRAS DE MOI | .DE) | |
|---|-------------------------------------|-----------------------------|---------------------|-------------------|
| Position(s) Applied For/Puesto(s) que solicita | | Date of Ap | olication/Fecha de | la Solicitud |
| | | 12 | rolar | |
| How Did You Learn About Us?/¿Cómo se enteró sobre no | osotros? | 100 | 11000 | |
| ☐ Advertisement/Anuncio ☐ Employment Agenc | | oleo 🗆 Inquiry, | /Vino por su cuenta | a |
| ☐ Relative/Pariente ☐ Friend/Amigo | □ Otl | er/Otro | | |
| Western and the second | | | 90.7 | |
| Fisher III | ne/Nombre(s) 2006 i e | G^{i} | Names! | |
| Address/Direction Number/Numero Street. (b) (4) | ⊄Calle | ∕Ciudad State√Es | tado′ Zip Code∦C | ódigð Pastal |
| L Teleptione Number(s)/Numero(s) de Teléfono | 58,7 (7 (4) - 2 %, 1°) | Social Security Nur | nber//Número de S | eauro Social |
| (b) (4) | | (b) (4) | Wahir | tarol |
| Best time to contact you at home is: La mejor hora para | comunicarse coi | usted en casa es: | any | - (AM) |
| If you are under 18 years of age, can you provide require | | | 1 | |
| Si es menor de 18 años, ¿puede proveer las pruebas rel | | | | □ No |
| Have you ever filed an application with us before? ¿Ha so | ilicitado empleo e | n esta empresa anteriormei | nte? 🗌 Yes/Si | r±√v _o |
| If Yes, give date En caso afirm | nativo, indique la | fecha | | |
| Have you ever been employed with us before? ¿ Ha trabe | ajado en esta emp | resa anteriormente? | 🗌 Yes/Si | O No |
| If Yes, give date En caso afirm | nativo, indique la | fecha ——————— | | |
| Do any of your friends or relatives, other than spouse, we ¿Trabaja en esta empresa elgún amigo o femiliar? | ork here? | | 🗹 Yes/Si | [] No |
| Are you currently employed? ¿Trabaja actualmente? | | | | U No |
| May we contact your present employer? ¿Nos autoriza a | | | | □ No |
| | | | | |
| Are you prevented from lawfully becoming employed in the ¿Tiene prohibido trabajar legalmente en este país a ceuse Proof of citizenship or immigration status will be required Si se le contrata se le pedirá prueba de ciudadanía o situ | a de su situación upon employmen | de inmigración o visa? t | | M. No |
| What is your desired salery range? Neg oficble | ¿Cual es el alca | nce de su salario deseado?. | | _ |
| Date available for work/¿En qué fecha estará disponible p | | | | |
| Are you available to work:/¿Está disponible para trabajar. | | | | |
| ☐ Full-Time/Tiempo Completo ☐ Part-Time/Tien | npo Parcial | ☐ Temporary/Temporari | o | |
| Are you currently on "ley-off" status and subject to recall? ¿Está ectualmente en despido temporal y sujeto a que lo | | - ?. | □ Yes/Sí | t No |

Education/Educación

| | Name and Address of School Nombre y Dirección de Escuela | Course of Study Curso de Estudios | Number of Years Completed Número de Años Terminados | Diploma/Degree <i>Título o</i> Diploma |
|--|---|--|--|--|
| Elementary School Escuela Primaria | | 名の では、 の | es established | |
| High School Escuela Secundaria | Pine River/ Backus Minnesota | Buisiness | 12 | Diploma |
| Undergraduate College Universidad de Pregrado | | | | |
| Graduate/Professional Posgrado/Profesional | | | | |
| Other (Specify) Otro (Especifique) | | 一次 一次 一次 一次 一次 一次 一次 一次 | | |

| Describe any specialized training, apprenticeship, skills and extra-curricular activities. Describa su capacitación especializada, aprendizaje, destrezas y actividades extracurriculares. | | | | |
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| Descr | Describe any job-related training received in the United States military. Describa la capacitación especializada relacionada con el empleo que haya recibido de las fuerzas armadas de los Estados Unidos. | | | | | |
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Employment Experience/Experiencia Laboral

Start with your present or last job. Include any job-related military service assignments and volunteer activities. You may exclude organizations which indicate race, color religion, genden national origin, disabilities or other protected status. Indique primero su empleo actual o su ultimo empleo, incluya las actividades de servicio militar relacionadas con su empleo y las actividades

Indique primero su emplea actual o su último emplea. Incluya las actividades de servicio militar relacionadas con su empleo y las actividades como voluntario. Está autorizado a excluir las organizaciones que indiquen su raza, color, religión, género, origen nacional, sus incapacidades físicas o mentales o cualquier otra condición protegida por la ley.

| 1. | Employer/Empleador | restarant | Dates Employed Fechas de Empleo | Work Performed/Traba | jo Realizado |
|----------------|---|-------------------------------|---|--|--|
| | Address/Dirección | lestarant | From/Desde To/Hasta | () () day (55 | |
| | Telephone Number(s)/Número(s) | de teléfono | Hourly Rate/Salary Paga por Hora/Sueldo | waitress | |
| | 1 ' 1 ' | upervisor/Supervisor | Starting/Inicial Final (b) (4) | | |
| | Reason for Leaving/Motivo por a | V Cual Dajá su Emplas | | | |
| | | to Port Arthu | , | | |
| 2. | Employer/Empleador | C C S 0 | Dates Employed Fechas de Empleo From/Desde To/Hasta | Work Performed/Traba | jo Realizado |
| | Address/Dirección Trinis | ry Tx | year | Waitress | |
| | Telephone Number(s)/Número(s) | de Teléfono | Hourly Rate/Salary Paga por Hora/Sueldo | | |
| | Job Title/Titulo del Empleo S いんいってとか | upervisor/Supervisor Dland | Starting/inic Plant Final (b) (4) | | |
| | Reason for Leaving/Motivo por a | | | | |
| 3. | Employer/Empleador | ster | Dates Employed Fechas de Empleo | Work Performed/Traba, | io Realizado |
| | Address/Dirección | ens Tx | From/Desde To/Hasta | Front Des | sk |
| | Telephone Number(s)/Número(s) | | Hourly Rate/Salary Paga por Hora/Sueldo | Front Des Clerk | |
| | 13-475-9314 Li Sa Sob Title/Titulo del Empleo So | upervisor/Supervisor | Starting/Inicial (b) (4) | | |
| | Stont desk Werk | Lisa_ | | | |
| | Reason for Leeving/Motivo por e | l Cual Dejó su Empleo | | | |
| 4. | Employer/Empleador | | Dates Employed Fechas de Empleo | Work Performed/Traba | jo Realizado |
| | Address/Dirección | | From/Desde To/Hasta | | |
| | Telephone Number(s)/Número(s) | de Teléfana | Hourly Rate/Salary Paga por Hora/Sueldo | | |
| | Job Title/Titulo del Empleo Si | upervisor/Supervisor | Starting/Inicial Final | | |
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| Y | ou may exclude membership which stá autorizado a excluir la participad | would reveal gender, race, r | religion, national origin, age, ai | ncestry, disability or other prote ad. ascendencia, incapacidad fis | cted status / |
| o | cualquier otra condición protegida | oor la ley: | | | |
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Additional Information/Información Adicional

| Summarize special joi | cations/Destrezas y Ca | lificaciones Especi | ales |
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| | b-related skills and qualifications acqui | | (******* ***************************** |
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| relacionadas con el e | mpled que solicita: | 10 10 10 10 10 10 10 10 10 10 10 10 10 1 | |
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| Specialized Skills/ | Destrezas Especializadas ((| Check Skills/Equipment Operated/Ma | rque sus Destrezas o Equipos que Puede Operar) |
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NAME/NOMBRE:

Applicant's Statement/Declaración del Empleado

l certify that answers given herein are true and complete./Certifico que las respuestas dadas en la presente son completas y verdaderas.

I authorize investigation of all statements contained in this application for employment as may be necessary in arriving at an employment decision.

This application for employment shall be considered active for a period of time not to exceed 45 days. Any applicant wishing to be considered for employment beyond this time period should inquire as to whether or not applications are being accepted at that time.

I hereby understand and acknowledge that, unless otherwise defined by applicable law, any employment relationship with this organization is of an "at will" nature; which means that the Employee may resign at any time and the Employer may discharge Employee at any time with or without cause, it is further understood that this "at will" employment relationship may not be changed by any written document or by conduct unless such change is specifically acknowledged in writing by an authorized executive of this organization.

In the event of employment, I understand that false or misleading information given in my application or interview(s) may result in discharge. I understand, also, that I am required to abide by all rules and regulations of the employer.

Autorizo la investigación de todas las declaraciones que aparecen en esta solicitud de empleo que sea necesaria para tomar una decisión sobre el puesto de trabajo que solicito.

Esta solicitud de empleo se considerará activa durante un periodo que no excederá los 45 días. Los solicitantes que deseen que se les considere para puestos de trabajo después de este periodo de tiempo, deberán preguntar si se aceptan o no solicitudes en ese momento

Por la presente entiendo y acepto que, a menos que lo definan de otra manera las leyes aplicables, todas las relaciones de trabajo con esta organización serán de tipo " a voluntad ", lo que significa que el Empleado podrá renunciar en cualquier momento y que el Empleador podrá despedir al Empleado en cualquier momento, con o sin causa. Además, se entiende que la relación de trabajo " a voluntad " no se podrá cambiar mediante ningún documento escrito ni por ninguna conducta, a menos que un ejecutivo autorizado de esta organización haya aceptado dicho cambio por escrito.

En caso que se me contrate; entiendo que toda información falsa o enganosa que haya dado en mi solicitud o en mi(s) entrevista(s) puede resultar en mi despido. Entiendo, además, que deberé cumplir con todas las regulaciones y reglamentos de mi empleador.

Signature of Applicant / Firma del Solicitante

Date / Fecha

This Application For Employment is sold for general use throughout the United States. Amsterdam Printing and Litho assumes no responsibility for the use of said form or any questions which, when asked by the employer of the job applicant, may violate State and/or Federal Law.

Esta Solicitud de Empleo se vende para uso general en todo Estados Unidos. Amsterdam Printing and Litho, no asume ningular responsabilidad por el uso de dicho formulario ni por ninguna pregunta que, cuando la formula el empleador al individuo que soprite empleo, pudiera violar las leyes federales y/o estatales.

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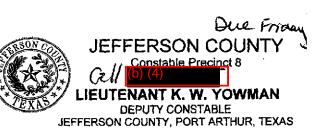
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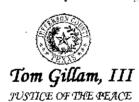


SUB-COURTHOUSE (409) 983-8311

525 LAKESHORE DRIVE (409) 983-8302

PORT ARTHUR, TEXAS 77640 FAX: (409) 983-8303

kyowman@co.jefferson.tx.us



TUSTICE OF THE FEACE

PRECINCT EIGHT

JEFFERSON COUNTY, PORT ARTHUR TEXAS

SUB-COURTHOUSE 525 LAKESHORE DRIVE PORT ARTHUR, TEXAS 77640

OFC: (409) 983-8330 FAX: (409) 749-3670



12/19/2008

C E S ENVIRONMENTAL SERVICES I 4904 GRIGGS RD HOUSTON TX 77021-3208 mmoset@cesenvironmental.com

Notification Confirming Receipt of Claim

Date of Injury:

12/18/2008

Injured Worker:

SUTTER, JOEY

Claim Number: Policy Number:

0001086044

Attached is a copy of the information you reported to Texas Mutual Insurance Company which was used to establish this claim. You may submit additional claim information to Texas Mutual Insurance Company. If you have questions regarding this report of injury please contact us at (800) 859-5995.

If your policy includes our workers' compensation health care network option you are required by law to obtain a second Employee Acknowledgement of Workers' Compensation Network Form signed by the injured worker. Please submit a copy of the signed, second acknowledgement form to Texas Mutual Insurance Company. You can find a copy of the form online at www.texasmutual.com/hcn/hcn,shtm

Below please find information that will help you through the claim process:

To submit additional claim information:

To locate a treating doctor:

Mail to: P. O. Box 12029 Austin, Texas 78711-2029

Austin, Texas 78711-2029 Fax to: (512) 224-3889 www.texasmutual.com/workers/iwADL.shtm

To contact the handling adjuster:

Call: (800) 859-5995

Monday - Friday; 8:00 a.m. - 5:30 p.m.

To obtain a copy of the Employer and Employee Rights and Responsibilities in the

Workers' Compensation System:

www.texasmutual.com/employers/erRights.shtm

To locate a pharmacy, or for pharmacy questions, contact Scripnet:

Call: (888) 880-8562 www.scripnet.com To obtain a copy of the Employer and Employee Rights and Responsibilities for the

workers' comp health care network: www.texasmutual.com/hcn/hcn.shtm

Additional Texas Mutual® online services at www.texasmutual.com, available 6 a.m. - 9 p.m., include:

- o Obtain logon id, or for immediate logon id, call (800) 859-5995, M-F, 8:00 a.m. 5:30 p.m.
- o Submit first report of injury in the Employers section
- o Submit wage statement when reviewing loss runs and claim details
- Obtain specific claim summary information



Claim Number:

99J0000556027

Notification Date: 12/19/2008

EMPLOYER'S FIRST REPORT OF INJURY

INJURED EMPLOYEE

Name: SSN:

JOEY SUTTER XXX-XX(b)

Mailing Address: TX

County: Physical Address:

County:

Home Phone:

Date of Birth: Marital Status: Not Married

Gender: Language: Male

Dependents: 00

English

MEDICAL PROVIDER

Name:

Tax ID: Address:

Phone:

Represented by Attorney:

Name:

Phone:

Fax:

ATTORNEY

Date of Injury:

12/18/2008

Time: 14:30

Date Reported: 12/18/2008

Nature of Injury: UNKNOWN/NOT REPORTED

Cause of Injury: MISC. CAUSES-OTHER

MISCELLANEOUS, NOC

Part of Body:

UNKNOWN/ NOT

REPORTED

Fatality: Yes BUSINESS/EMPLOYER

Name: CESENVIRONMENTAL SERVICES I

Address:

4904 GRIGGS RD

HOUSTON TX 77021-3208

Phone: (713)676-1460

Ext:

Fax:(713)676-1676

Policy Number:

0001086044

FEIN:

760592985

Location ID:

<u>EMPLOYMENT</u>

Occupation: WAREHOUSE

Hire Date: 00/00/0000

Partner/Officer/Owner:

00/00/0000

Date Lost Time Began: Return to Work Date:

00/00/0000

State: TX

Last Paycheck was:

Wage: Frequency:

Hours/Week:

Days/Week:

Period Start: 00/00/0000

Period End: 00/00/0000

Supervisor Name:

Phone:

Ext:

PREPARER OF REPORT

Name: CHAD

Phone: (713)966-1796

Ext:

Fax:

Email: mmoser@cesenvironmental.com

INJURY INFORMATION

Address Where Injury Occurred:

2420 GULFWAY DR

PORT ARTHUR TX 77640-4541

County: JEFFERSON

Witnesses:

Name:

Phone:

Name:

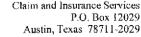
Name:

Phone:

Phone:

How and Why the Injury/Illness Occurred

FATALITY. EE WAS CLIMBING ON A TRUCK TO HELP IN THE CHEMICAL VENTING PROCESS. EE STARTED BLEEDING FROM HIS NOSE AND FAINTED. EE PASSED DUE TO ANEURYSM.



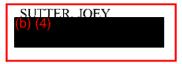


NOTIFICATION OF FIRST DEATH BENEFIT PAYMENT

DATE:

06/02/2009

RE:



Date of Injury: 12/18/2008

Nature of Injury: NO PHYSICAL INJURY
Part of Body Injured: NO PHYSICAL INJURY

Employee SSN:
DWC #:

Carrier Name:

Carrier Name:

Carrier Claim Number:

Employer:

Texas Mutual Insurance Company

(b) (4)

09169549

C E S ENVIRONMENTAL SERVI

4904 GRIGGS RD

HOUSTON TX 77021-3208

Your first payment of workers' compensation benefits for the period of 12/19/2008 is being issued. The benefit payment is called "Death Benefits" (**DBs**) and is paid weekly. Your DBs payment, in the amount of \$570.36, is based on 75% of the reported Average Weekly Wage of \$760.48. An explanation of your DBs payment is as follows:

we are in receipt of a DWC 42 with supporting documentation with regards to a documented beneficiary, Ashley Nicole Sutter. These benefits have been calculated by taking 50% of \$570.36 dividing it by 3. This amount will be used at \$95.06 until further notice. Remaining amount will be kept in escrow until further determination is made with regards to other potential beneficiaires.

You may request that we make benefit payments by electronic funds transfer directly to your bank account. Also, you may request that we change your DBs from a weekly payment to a monthly payment.

If you do not agree with the amount of weekly death benefits being paid, please contact me:

Adjuster's Name: KARIN T. CROUSE Toll Free Telephone #: (800) 859-5995
Fax #/E-mail Address: (512) 224-3889

If we are unable to resolve the issue to your satisfaction, you may contact the Texas Department of Insurance, Division of Workers' Compensation for further assistance. You have the right to request a Benefit Review Conference. You can contact the Division office handling your claim at 1-800-252-7031.

If you would like to receive notices such as this by facsimile or e-mail, please contact me and provide your facsimile number or e-mail address.

Please note that making a false or fraudulent workers' compensation claim is a crime that may result in fines and/or imprisonment.

C SUTTER, ASHLEY NICOLE C E S ENVIRONMENTAL SERVI



CES Environmental Services, Inc. 4904 Griggs Road Houston, TX 77021 713-676-1460 Main 713-676-1676 Fax

Mr. Mark Sokolow City Attorney City of Port Arthur 444 4th Street, Suite 426 Port Arthur, TX 77640

RE: PACES and Autopsy of Joey Sutter

Dear Mr. Sokolow:

The recent Joey Sutter Autopsy Report released after April 17, 2009, had several incorrect statements and omitted information. Susan Jones at Southeast Texas Forensic Center (Jefferson County Morgue) stated that the sulfhemoglobin in blood test identified on the NMS Labs Report Issued January 20, 2009 had results below testing limits and that the Toxicology Report can be revised to clearly reflect this fact. This biological marker used to indicate hydrogen sulfide exposure reflected no exposure with the low results below testing limits.

The Joey Sutter Autopsy Report did not acknowledge that the NMS Labs Report of January 20, 2009, showed the thiosulfate levels in Mr. Sutter's urine were normal. This is another biological marker for hydrogen sulfide exposure that reflected no excessive exposure.

The NMS Labs Report of March 25, 2009 did not acknowledge the results of the sulfhemoglobin blood test or thiosulfate level in urine report of January 20, 2009. The NMS Labs Report of March 25, 2009, based the hydrogen sulfide poisoning on one thiosulfate test in a blood sample that was 2.5 months old or 1.5 months beyond NMS Labs sample stability limit of one month.

The Joey Sutter Autopsy Report dated April 17, 2009 written by T. Brown is based on the March 25, 2009 NMS Labs Report that omitted information, used an old unstable blood sample, and contained other incorrect information. Both reports state that the site operator was boiling wastewater in a sealed tank (trailer). However, there was not any steam heat available at the site and no other source of heat was being used. The material in the truck trailer was oil not wastewater. (See Attached OSHA Data) Both reports omitted OSHA and PAFD testing that shows no hydrogen sulfide in Joey Sutter's clothes. Both reports

omitted OSHA data showing analysis of the gas head space over the oil sample from the trailer which reported no hydrogen sulfide. (See Attached OSHA Data)

Both reports state that the dome lid was opened by Joey Sutter when in fact the dome lid was not opened at all.

The Joey Sutter Autopsy Report written by T. Brown (04/17/09) states that Mr. Sutter was knockdown and deprived of life due to hydrogen sulfide poisoning. Technical information states that hydrogen sulfide concentrations required to knockdown must be 700 to 1000 ppm. As you can see by the attached information, Mr. Sutter was not alone on the trailer and that his fellow worker's personnel H2S alarm set at 10 ppm never activated. This also places the Sutter Autopsy Report findings in doubt, since the second person on the trailer within two feet did not have any ill effects from hydrogen sulfide, or alarm activiated.

After review of the two biological markers, negative sulfhemoglobin levels in the blood and normal thiosulfate in urine, nearby hydrogen sulfide monitor alarm information, information that nearby workers were not harmed by any hydrogen sulfide, incorrect circumstantial information, and the one data point of thiosulfate in blood that was based on an old unstable blood sample and used as the basis for Mr. Brown's Autopsy Report of Joey Sutter, we believe that the autopsy came to the wrong conclusion about hydrogen sulfide exposure. In fact, Mr. Sutter had high blood pressure, enlarged heart and was obese.

We have attached information regarding the second death (Charles Brent Sittig) which shows no exposure to hydrogen sulfide and that Mr. Sittig was not in any work related activity at the time of death.

In addition, Mr. Sittig was over weight with possible blood pressure issues. (See Attached Information)

If you have any questions, please call me.

Very truly yours,

Matt Bowman

Two Incident Reports Joey Sutter and Charles Sittig

Joey Sutter

Pre-Incident

Several days before December 17, 2008 Trailer 267 was loaded with oil from an emulsion breaking process at the PACES site 2420 South Gulfway, Port Arthur, TX.

On December 17, 2008, Brian Weathers sampled Trailer 267, removing a sample of the oil from inside the trailer. (See Attachment 1)

Incident

On December 18, 2008, at 2:00pm, Suzi Mock and Joey Sutter went to Trailer 267 to resample the oil in the trailer. Ms. Mock climbed to the top of Trailer 267 first. Mr. Sutter started up the ladder after and behind Ms. Mock. As Mr. Sutter reached the top of the latter he collapsed. Ms. Mock grabbed Mr. Sutter so he would not fall from the Trailer 267. Ms. Mock pulled Mr. Sutter to the top of the Trailer 267. Mr. Sutter and Ms. Mock did not open the dome lid nor did she or Mr. Sutter obtain a sample at this time. This was at 2:00pm, Thursday, December 18, 2008.

Ms. Mock called for help and at 2:10pm (12/18/08) the Port Arthur Fire Department was notified. (See Attachment 2) Within a few minutes of 2:00pm (12/18/08) Mr. Wood went to Ms. Mock to assist her with Mr. Sutter. Mr. Wood also assisted Ms. Mock to turn Mr. Sutter over, still on top of the Trailer 267.

At 2:20pm (12/18/08) the Port Arthur Fire Department arrived and by 2:35pm, Mr. Sutter was removed from the top of the Trailer 267 by the Port Arthur Fire Department. (See Attachment 2)

Ms. Mock did not experience any illness from any hydrogen sulfide release when she was with Mr. Sutter on top of the Trailer 267. Ms. Mock's personal hydrogen sulfide monitor did not trigger when she was on top of the Trailer 267. Ms. Mock's monitor was set to alarm at 10 ppm hydrogen sulfide. Mr. Wood did not experience any illness from hydrogen sulfide while assisting Mr. Sutter.

The Port Arthur Fire Department placed Mr. Sutter's clothes and the Port Arthur Fire Department hydrogen sulfide meter in a bag. The Port Arthur Fire Department measured a reading of -0- hydrogen sulfide. The Port Arthur Fire Department returned to the top of Trailer 267 two hours after Mr. Sutter was removed and measured only 1 ppm hydrogen sulfide. (See Attachment 2)

May 27, 2009 Two Incident Reports Page 1 of 4

Post Incident

OSHA tested Mr. Sutter's clothes for hydrogen sulfide and did not find any hydrogen sulfide. (See Attachment 3) OSHA tested the head space over an oil sample from Trailer 267 and did not find any hydrogen sulfide. (See Attachment 4)

Hydrogen sulfide technical information sources state that it takes 700 to 1000 ppm of hydrogen sulfide to knockdown an individual with hydrogen sulfide. In addition, when a group of people are together near a hydrogen sulfide release all persons suffer health problems. (See Attached 5)

OSHA measured organic sulfur compounds in the oil which exhibits a smell similar to hydrogen sulfide, but the organic sulfur compounds are liquid at ambient temperatures and not a toxic gas.

In addition, the oil in Trailer 267 was not heated prior to the December 18, 2008 incident, since no steam was available and the trailer had been loaded prior to December 17, 2008 without any modifications of the oil for two days. (See Attachment 6)

In summary, pre-incident information and post incident information does not support the concept that hydrogen sulfide was released from a trailer during a short time of a few minutes at such level of 700 to 1000 ppm to cause one of two people side-by-side to collapse and die in minutes while the second person is holding on to the dying person without having her personal hydrogen sulfide alarm activate. (See Attachment 7)

In addition, a third person climbed to the top of Trailer 267 to assist the two already on trailer without getting sick from hydrogen sulfide. Also, the Port Arthur Fire Department representative did not note any problems with anyone other than Mr. Sutter. Remember, Trailer 267 was sampled the day before with out any problems.

Joey Sutter Autopsy Comments

The autopsy based its conclusions on a lab report from NMS Labs dated March 25, 2009. This NMS Labs Report based its conclusion on one test of one blood sample which was received on March 5, 2009 by NMS Labs, when the death occurred on December 18, 2008. This delay in testing appears to have violated acceptable protocols.

The NMS Labs Report did not state that Mr. Sutter died from hydrogen sulfide poisoning. The report stated that the measured value of thiosulfate in the blood sample was similar to values found in four other situations where people were believed to have died from hydrogen sulfide. However, the thiosulfate value of 43% of the cases were above 11 mcg/ml (value measured in Mr. Sutter's blood) and 43% were below the 11 mcg/ml value. The NMS Labs Report did not speak to another NMS Labs analysis report on urine from Mr. Sutter received January 15, 2009. (See Attachment 8)

May 27, 2009 Two Incident Reports Page 2 of 4

This report stated that thiosulfate in urine was normal. Technical information states that thiosulfate in urine is just as valid as thiosulfate in blood for measuring hydrogen sulfide exposure.

Both the NMS Labs Report of March 25, 2009 and the T. Brown Autopsy Report of April 17, 2009 omitted the sulfhemoglobin in blood data identified in the NMS Labs Report of January 20, 2009. Susan Jones at Southeast Texas Forensic Center (Jefferson County Morgue) stated that the sulfhemoglobin measured levels were below testing limits. As a biological marker the test data reflects no exposure to hydrogen sulfide.

Both the NMS Labs (3/25/09) report and the Mr. Sutter Autopsy had many facts wrong. For example, both stated that the site operator (PACES) was boiling water in a closed dome tank (trailer) to drive off hydrogen sulfide. Remember, this material is oil in a tanker which is not heated, since no steam was available. Also, the thiosulfate analysis of the blood did not follow correct procedures, where the thiosulfate test in the urine did follow correct lab procedures.

The Sutter Autopsy Report did show that Mr. Sutter was over weight to the point of being obese and a smoker. Mr. Sutter's blood pressure values of August 2008 were 136/90. These numbers reach the level of Stage 1 Hypertension. Technical data states that hypertension can result in hardening of the arteries, enlarged heart, and other health issues. The T. Brown Autopsy Report (04/17/09), states that Mr. Sutter had cardiomegaly (an enlarged heart). The risk of complications from an enlarged heart are heart failure, blood clots, cardiac arrest, and sudden death.

Charles Brent Sittig

Incident

On April 14, 2009, Charles Brent Sittig (truck driver for PACES) returned to the site with a load of weak caustic solution that was not loaded by him. Mr. Sittig parked the tractor and trailer to be unloaded by another person and moved away from the trailer into the maintenance office area of the plant site.

Mr. Sittig sat in a chair and collapsed while making a telephone call. Mr. Sittig was a few feet away from the maintenance person who went to him after he collapsed. The maintenance person did not have any affects from hydrogen sulfide and there was not any hydrogen sulfide release or triggered any alarms.

Post Incident

The material from Mr. Sittig's truck was placed in NV1 Tank and tested for sulfides. The measured sulfide in the material was less than 1 ppm sulfide (See Attachment 9).

Data from Mr. Sittig's file shows that he was overweight. In the past his blood pressure was close to values that would disqualify him as a driver.

May 27, 2009 Two Incident Reports Page 3 of 4

In summary, Mr. Sittig was not engaged in activity at the time of death. There was no hydrogen sulfide released at the time of his death. Mr. Sittig was near others that did not experience any hydrogen sulfide problems and his trailer contained material that was below 1 ppm sulfide which he did not load or unload.

Summary of Both Incident Reports (Mr. Sutter and Mr. Sittig)

Hydrogen sulfide poisoning could have not been the mechanism that caused the two deaths, since the exposure level (700 to 1000 ppm) required to knockdown and kill quickly would have affected companions, triggered alarms, showed up in clothes, and introduced odors over a wide area since the odor threshold of hydrogen sulfide is 0.005 ppm.

In addition, low levels of hydrogen sulfide over long periods of time would not have been a factor in the deaths since recent and past results show no adverse impacts from low levels of hydrogen sulfide. Most recent data shows that low levels of hydrogen sulfide lowers blood pressure. (See Attachment 10)

However, both Mr. Sutter and Mr. Sittig had weight and blood pressure issues that were significant and indicators of personal health issues.

May 27, 2009 Two Incident Reports Page 4 of 4

Attachment

1

General Affidavit

| STATE OF TEXAS |
|--|
| COUNTY OF Jefferson |
| BEFORE ME, the undersigned Notary, Tatricia GRACE Fruge, on this |
| , 2009, personally appeared <u>Brian Weathers</u> |
| known to me to be a credible person and of lawful age, who being by me duly |
| sworn, on his oath, deposes and says: |
| My name is Brian Weathers. I am over 21 years of age. I was the Supervisor on December 17, 2008 and on December 18, 2008 at the Port Arthur Chemical and Environmental Services, LLC ("PACES") plant site at the time Joey Sutter passed away. I have personal knowledge and experience with the PACES' personal H ₂ S Monitoring Equipment and Sampling of Trailers. Puring of December 17, 2008 my H ₂ S alarm at PACES did not sound an alarm warning when I obtained a sample from Trailer 267. H ₂ S Monitor was set at 10 ppm H ₂ S to alarm on December 17, 2008 when I sampled the Trailer 267. |
| Dran feathers |
| (Signature of Affiant) |
| Brian Weathers (Printed Name of Affiant) |
| (b) (4) (Address of Affiant, Line 1) |
| (Address of Affiant, Line 2) |
| STATE OF TEXAS |
| COUNTY OF Jefferson |
| Sworn to and subscribed before me on this 3 day of March, 200%, |
| SEA Patricia Grace Krayer Notary Public Signature) (Notary Public Signature) Wy Commission Express May 29, 2010 |
| A CONTRACTOR OF THE CONTRACTOR |

Attachment

2

| MM DD NH715 | YYYY 2008 2 08-001288 Station Incident Number | i lulange ! Easic |
|---|--|---|
| B Location* Check this box to Indicate that the address for this incident is provided on the Mildland Fire Census Tract | | |
| X Street address Intersection Number/Milepost Prefi | Gulfway × Street or Highway RT ARTHUR | DR Street Type Suffix TX 77640 - State Zip Code |
| Adjacent to Directions | | |
| Cross street or directions, as applicable | | |
| C Incident Type * | E1 Date & Times | E2 Shift & Alarms |
| 321 EMS call, excluding vehicle Incident Type | Check boxes if Month Day) dates are the same as Alarm ALARM always required | Year Hr Min Sec Local Option |
| D Aid Given or Received* | Date. Alarm * 12 18 | 2008 14:10:33 Shift or Platoon District |
| 1 Mutual aid received | ARRIVAL required, unless cancels [X] Arrival * 12 18 | 20001124 . 70 . 00 1 |
| 2 Automatic aid recv. Their FDID Their State | CONTROLLED Optional, Except for | <u></u> <u></u> |
| Mutual aid given Automatic aid given | []Controlled | Local Option |
| 5 Other aid given Their Incident Number | LAST UNIT CLEARED, required excep | |
| N X None | X Cleared 12 18 | 2008 16:45:03 Special Special Study IDH Study Value |
| F Actions Taken * | G1 Resources * G2 | Estimated Dollar Losses & Values |
| | Check this box and skip this section if an Apparatus or | LOSSES: Required for all fires if known. Optional for non fires. |
| 23 Extricate, disentangle | Personnel form is used. Apparatus Personnel Pro | 110110 |
| Primary Action Taken (1) | Suppression 0002 0006 | |
| 33 Provide advanced life | | - · · · · · · · · · · · · · · · · · · · |
| Additional Action Taken (2) | | PRE-INCIDENT VALUE: Optional |
| Additional Action Taken (3) |) | perty \$, 000, 000 |
| Additional Action Pages (3) | Check box if resource counts include aid received resources. | ntents \$, 000, 000 |
| Completed Modules H1*Casualties | None H3 Hazardous Materials | Release I Mixed Use Property |
| Fire-2 Deaths Inj | uries N None | NN Not Mixed 10 Assembly use |
| Structure-3 Fire Service | 1 Natural Gas: slow leak, no evausti | on or MaxWat actions 20 Education use |
| Civil Fire Cas4 | 2 Propane gas: <21 lb. tank (as in) 3 Gasoline: vahitle fuel tank or porta | |
| CIVIII C | 4 Kerosene: fuel burning equipment or | 51 Row of stores |
| H2 Detector Required for Confined | E []Diego] fuol/fuol oil. | |
| Wildland Fire-8 1 Detector slerted occ | 6 Thousehold selection | |
| X Apparatus-9 X Personnel-10 2 Detector did not all | 7 Motor oil: from engine or portable | \$ 62 [MITITARY ase |
| X Personnel-10 2 Detector did not all | Paint: from point came totaling < 55 g | 1 03 11 22 22 22 |
| OL material | 341 Clinic, clinic type infirmary | |
| J Property Use* Structures | 342 Doctor/dentist office | 579 Motor vehicle/boat sales/repair |
| 131 Church, place of worship | 361 Prison or jail, not juvenile | 571 Gas or service station |
| 161 Restaurant or cafeteria | 419 1-or 2-family dwelling | 599 Dusiness office |
| 162 Bar/Tavern or nightclub 213 Elementary school or kincergarten | 429 Multi-family dwelling 439 Rooming/boarding house | 615 Electric generating plant 629 Laboratory/science lab |
| 215 [High school or junior high | 449 Commercial hotel or motel | 700 Manufacturing plant |
| 241 College, adult education | 459 Residential, board and care | 819 Livestock/poultry storage(barn) |
| 311 Care facility for the aged | 464 Dormitory/barracks | 882 Non-residential parking garage |
| 331 Hospital | 519 Food and beverage sales | 891 Warehouse |
| Outside | 936 Vacant lot 938 Graded/care for plot of land | 981 Construction site 984 Industrial plant yard |
| 555 Crops or orchard | 946 Lake, river, stream | - · |
| 69 [Forest (timberland) | 951 Railroad right of way | Lookup and enter a Property Use code only if you have NOT checked a Property Use box: |
| 107 Outdoor storage area | 960 Other street | Property Use 891 |
| 19 Dump or sanitary landfill 31 Open land or field | 961 Highway/divided highway 962 Residential street/driveway | Warehouse |
| | <u></u> | NFIRS-1 Revision 03/11/99 |

| K1 Person/Entity Involved | ECA Environmental Services 409 - 293 - 6854 Business name (it applicable) Area Code Phone Number | |
|---|---|--|
| | | |
| Check This Box if Mr. Ms. Mrs. Pirst incident location. | 4 | |
| Then skip the three duplicate address lines. | S Gulfway DR Street or Highway Screet Type Suffix | |
| | PORT ARTHUR | |
| Post Office Box | Apt./Suite/Room City | |
| TX 77640 | | |
| State zip (bde | - I I | |
| | s box and attach Supplemental Forms (NFIRS-1S) as necessary | |
| K2 Owner Same as person involved? Then check this box and skip The rest of this section. | Business name (if Applicable) Area Code Phone Number | |
| Check this box if Mr.,Ms., Mrs. First | Name MI Last Name Suffix | |
| same address as incident location. | t it | |
| Then skip the three duplicate address Number | Prefix Street or Highway Street Type Suffix | |
| lines. | 1 1 | |
| Fost Office Bcx | Apt./Suite/Room City | |
| 1 11 | 1-1 } | |
| State Zip Code | | |
| L Remarks Local Option < <logs>> 14:11:03 00005150</logs> | : sc enrte ; 14:14:36 00005062 : PER 5014 CALL BACK ADVISED | |
| FULL ARREST/E2 EMS ADVISED ; 14:19:30 00005062 : E2 1410 1419 ; 14:19:54 00005062 : | | |
| RETONE ; 14:20:17 00005062 : W2 REQUEST R1 ASSIST ; 14:21:44 00005062 : TURN AT | | |
| TALON'S/ENVIRONMENTAL//RD BEFORE IC BRIDGE ST COM ON RIGHT DOWN DIRT RD ; 14:28:08 00005145 | | |
| e2-heavy set man ontop of the tanker; 14:30:06 00005145 : bringing him down now; | | |
| 14:33:23 00005145: hrl has a firefighter riding with ems to hospital enroute to pick him up | | |
| ///st mary ; 14:45:56 00005145 : e2 to st marys to give information ; 14:56:51 00005145 : | | |
| e2 at st mary; 15:03:45 00005145 : told unit 3 to call the chief the hospital is treating | | |
| this as a hazmat incident; 15:19:40 00005145: e2 leaving st mary going back to scene; 15:31:04 00005145: hr1 toned out of service; 15:32:18 00005145: e2 back on the csene; | | |
| 16:04:51 00005145 : msds is non toxic ; 16:07:20 00005145 : e2 back in service going to | | |
| station ; 16:14:27 00005145 : ernout to st mary hospital ; 16:23:31 00005145 : at st mary | | |
| again ; 16:45:03 00005145 : Incident Closed ; | | |
| w.xxxxxx=============================== | | |
| On 12/18/2008 at 14:10:33 dispatched To 2420 S Gulfway DR /PORT ARTHUR, TX 77640. The | | |
| location is a Warehouse. The incident was determined to be a(n) EMS call, excluding | | |
| vehicle accident with injury. | | |
| | | |
| 14:19:20 arrived on scene. | | |
| The following actions were performed on scene: Extricate, disentangle | | |
| Provide advanced life support (ALS) | | |
| | | |
| Units responding were: | | |
| Unit E2 responded. | | |
| | | |
| L Authorization | | |
| | | |
| 29450 PEAI | Position of Yank Perignment Month Pay Vet | |
| Officer in charge ID Signatu | re | |
| Check Box if X 129450 PEAK | E, THOMAS W CA 12 18 2008 | |
| BOX 11 X Signature as Officer Member making report ID Signature | Position or rank Assignment Month Day Year | |
| in charge. | | |

ort Arthur F.D.

NH715 12/18/2008 08-0012882

MiV DD YYYYComplete NH715 TX 12 18 2008 08-0012882 000 Narrative State * Incident Date + Incident Number * FDID Station Ежровите 🛧

Narrative:

On 12/18/2008 at 14:10:33 dispatched To 2420 S Gulfway DR /PORT ARTHUR, TX 77640. The location is a Warehouse. The incident was determined to be a(n) EMS call, excluding vehicle accident with injury.

14:19:20 arrived on scene.

The following actions were performed on scene:
 Extricate, disentangle
 Provide advanced life support (ALS)

Units responding were: Unit E2 responded. Unit HR1 responded. Unit SC63 responded.

16:45:03 all units back in service.

Dispatched to difficulty breathing. While enroute the call was upgraded to a full arrest. AOSTF patient on top of a tanker. Company emloyees had begun cpr. Fire engineer Barideaux and fire fighter Delacerda climbed on top of tanker and took over cpr. Captain Peake directed resources needed for the retrieval of patient from atop the tanker. Company employee made mention that the patient may have been exposed to toxic fumes. FD backboarded the patient and lowered the patient to the ground and onto waiting Stat Care ems stretcher. Fire fighter Thibedeaux rode with patient to SMH to assist ems.

HR1 went to SMH while E2 gathered patient info. E2 went to SMH and found hospital doing a hazmat wash on patient. E2 returned to scene to take drager readings from top of tanker. Drager read 1 ppm of H2S. Obtained msds sheet on tanker contents. Msds showed chemical to be sulfurized isobutylene. Toxicological Data showed all areas to be: Practically non-toxic. E2 returned to SMH msds sheet for distribution to the hospital and JP. E2 returned to service.

HR-1 Supplement:

HR-1 responded to assist. FF Thibodeaux rode in with EMS to St. Mary. Upon arrival the EMS staff complained of a strong odor from the pt. and his clothing. Hospital staff removed clothing and placed into a biohazard bag. FD placed a meter in the bag. The meter detected no lel, no H2S, no CO, and indicated an O2 % of 20.9. The deceased was placed in a secure room ouitside of the ER. FF Thibodeaux was provided with scrubs from the hospital and was

rt Arthur F.D. NH715 12/18/2008 08-0012882

| | | MM DD | YYYY | | | | |
|--------|--------------|---------------|------|---------|-------------------|------------|-----------|
| NH715 | TX | 1 12 18 | 2008 | 1 2 1 | 08-0012882 | 1 000 1 | Complete |
| FDID 4 | State | Incident Date | 2000 | Station | Incident Number _ | J | Narrative |
| | क | * | | Deneron | * | Exposure 🛨 | <u> </u> |

Narrative:

able to remove her clothing and shower. Capt. Achord and FE Richard donned class B suits and airpacks and assisted in placing the deceased into two body bags for transfer to the morgue. Both the class B suits and the pt.'s clothing went with the decedant to the morgue.

rt Arthur F.D. NH715 12/18/2008 08-0012882

| NH715 | MM DD YYYY TX 12 18 2008 State * Incident Date * | 2 Station | | -0012882 | Exposure * | Delete | FIRS - 10 Personnel | |
|----------------------------|---|-----------------------------------|-------------|--------------------------|--|--|------------------------|--|
| B Apparatus or Resource | Check if same as alarm date | Hours/mins | Sent | Number of * People | Use Theck ONE box for eat apparatus to indicate its main use at the incident. | Actions Taken List up to 4 actions for each apparatus and each personnel. | | |
| 1 ID E2 Type 11 | Dispatch X 12 18 2008 Arrival X 12 18 2008 Clear X 12 18 2008 | | Sent X | 3] | X Suppression EMS Other | | | |
| Personnel ID | Name | Rank or Grade | Attend | Actic | | Action Taken | Action Taken | |
| 29450 49817 70785 | PEAKE, THOMAS DELACERDA, TRAVIS BARIDEAUX, THADDEUS | CA FF FF | x x x | | | | | |
| 2 ID HR1 | Dispatch X 12 18 2008 | 14:30 | Sent X | 31 | Suppression EMS Other | | | |
| Personnel ID | Name | Rank or Grade | Attend | Actic Take | | Action Taken | Action Taken | |
| 30005 | ACHORD, JON RICHARD, BRANDAN THIBODEAUX. ANGELL | CA FE FF | X X X | | | | | |
| 3 ID SC63 | | 3 14:10 B 14:22 B 16:45 | Sent X | <u> </u> | Suppression Kens Other | | | |
| Personnel ID | Name | Rank or Grade | Attend | Actio | i 1 | Action Taken | Action Taken | |
| | | | | | | | | |



Port Arthur Fire Department Haz-Mat Sampling Tanker Unit 267 (Close-up)

See Port Arthur Fire Department Incident Report # 08-0012882 Page 3 HR-1 Supplement
Indicating Draeger Read of 1 ppm of H2S (Incident Report Attached)

Attachment

3

| Air Sampli | na Repo | xt U.S | . Departe | ment of La | bor Oc | cupation | al Safety | and Heal | ch Adm | inietrat | ion. | |) | |
|--|--|---|--|---|--|---|---------------------|-----------------|-------------|---------------------|---|----------|--------|-----|
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| 1. Reporting In | 6700 | | 2. Inape | ection Num | nper | 1 | 3. Şampli Number | ng [| > 4 | 1013 | 266 | 508 | | |
| 4. Escablishmen | t Name | | | CHEMICA AL SERVI | | <u>.</u> | | | | | · · · · · · · · · · · · · · · · · · · | | | |
| S. CSHO ID | | 6. SM | mpling Da | t∈ | 7. | Shippi | ng Date | | 8. | Date Res | mlt Ré | eceived | | |
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| 12. Frequency o | і Ехроя | ure | | | | | | | _ | | | | | |
| Exposure Summar | . У | | , | | | | | · | | | _ | | | |
| 14. | 15. Equal | 16. Sep1 | 17.Бжр Тура | 19.Exp Lavel | 19. Unite | 20. PEL | 1 . 1 | 22. Severity | | itation FTA Over | , , , , , , , , , , , , , , , , , , , | etion | or Med | 078 |
| Substance Code | | тура | "- | <u> </u> | | <u> </u> |]] | | Cit | gxb | | | | |
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Sampling Mumber: 401376608

M225 Qualitative Mass-Spec Analysis

Attachment

4

| Page 1 of 2 1. Reporting ED | Air Samplin | g Repo | rt U. | S. Departm | ent of Lab | oor (| Decupation | and Se | fety | and Heel | ch A | dminist | ration. | | | _ |
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PARTS PER MILLION

MICROGRAMS

Sampling Number: 401326616

PICO CURIES PER LITER (RADON GAS)

PIBERS PER CUBIC CENTIMETER

MILLIGRAMS PER CUBIC METER

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Attachment

5

Hydrogen Sulfide Poisoning: Clarification of Some Controversial Issues

Thomas H. Milby, MD,* and Randall C. Baselt, PhD1

Background Hydrogen sulfide is a toxic gas about which much has been written. We discuss here several issues we believe would benefit from further clarification.

Conclusions We conclude that: 1) Certain neurotoxic effects of exposure are probably due to a direct toxic effect on the brain, while others are almost certainly a result of hypoxia secondary to H_2S -induced respiratory insufficiency; 2) pulmonary edema is a common consequence of poisoning and there is suggestive evidence of hyperactive airway responses in some individuals following brief H_2S -induced unconsciousness (knockdown); 3) criteria for acceptable community levels are very different than those governing occupational standards; 4) urinary thiosulfate determinations can be useful for monitoring occupational exposure; and 5) determination of sulfide ion concentrations in blood or major organs can be useful in corroborating a diagnosis of fatal H_2S toxicity, but there are many pitfalls in collecting, storing, and analyzing tissue and fluid samples. Am. J. Ind. Med. 35:192-195,1999. © 1999 Wiley-Liss, Inc.

KEY WORDS: hydrogen sulfide; neurotoxic effects; pulmonary edema; urinary thiosulfate; blood sulfide.

INTRODUCTION

There have been several reviews of the toxicity of hydrogen sulfide to humans published in the last several decades [Milby, 1962; NRC, 1979; Beauchamp et al., 1984; Reiffenstein et al., 1992; EPA, 1993]. In the view of the authors, the majority of the data presented in these reviews continues to be valid, but some issues deserve further clarification. In this short communication, we consider the neurotoxic effects of acute exposure, effects on the lungs, community exposure issues, and diagnosis of poisoning utilizing urine, blood, and tissue analyses.

NEUROTOXIC EFFECTS

The above-cited reviews are generally consistent in the view that the most dramatic potential consequences of hydrogen sulfide exposure occur at high concentrations. At

750–1,000 ppm, inhalation of hydrogen sulfide causes abrupt physical collapse. If exposure is promptly terminated, many cases of collapse are followed by rapid and complete recovery. However, in some instances, presumably where exposure is more pronounced or prolonged, sudden collapse may give way to rapidly fatal respiratory paralysis [Milby, 1962; EPA, 1993; Guidotti, 1994].

Certain transitory neurotoxic effects associated with exposure to hydrogen sulfide such as dizziness, incoordination, and headache are probably due to the direct toxic effect of hydrogen sulfide on the brain: these effects appear far too quickly to be attributed to hypoxia. A phenomenon referred to as "knockdown" has been reported in oil field workers and others to describe sudden, brief loss of consciousness followed by immediate full recovery after short-lived exposure to very high concentrations of hydrogen sulfide (c.g., 750–1,000 ppm) [Guidotti, 1994; Aves, 1929; Smith and Gosselin, 1979]. Knockdown is likely a consequence of a direct toxic effect of hydrogen sulfide on the brain. This direct effect is believed to be due to the intracellular inhibition of cytochrome oxidase by sulfide ion, preventing utilization of oxygen [Nicholls, 1975].

Most victims of acute hydrogen sulfide poisoning who recover do so promptly and completely [Milby, 1962; NRC,

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Case Report

Two fatalities by hydrogen sulfide poisoning: Variation of pathological and toxicological findings

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Available online 8 February 2008

Abstract

We report the simultaneous deaths of two individuals by inhalation of hydrogen sulfide (H₂S), produced either by the putrefaction of a large quantity of sweet corn or by heavy oil that flowed out of the fuel tank of a large stranded cargo vessel. Ten workers went into a water ballast tank of the vessel to remove remaining heavy oil and suddenly felt unwell. Two of the ten workers (patient A, a male in his early thirties, and patient B, a male in his early sixties) died. Autopsies of the two patients revealed a partial green discoloration of the skin and pulmonary edema. Toxicological analysis revealed high levels of thiosulfate in the blood (0.089 mmol/L in patient A and 0.142 mmol/L in patient B). From these findings, we concluded that the cause of death in both patients was H₂S poisoning. In addition, the autopsy of patient A revealed petechiae of the palpebral conjunctiva and the mucous membrane of the mouth and erosion of the respiratory tract. The autopsy of patient B failed to reveal these observations. We presumed that patient B may have been exposed to higher H₂S levels, and that the circulation and respiration of patient B may have arrested faster than patient A. Thiosulfate levels in the blood may reflect the levels of H₂S exposure. This case suggests that the pathological and toxicological findings of H₂S poisoning vary from case to case.

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Keywords: Hydrogen sulfide poisoning; Thiosulfate; Pulmonary edema; Autopsy

1. Introduction

Hydrogen sulfide (H₂S) is a colorless irritant gas that is inflammable and water-soluble. H₂S has a specific gravity of 1.19 (air = 1.00) and the characteristic odor of rotten eggs [1]. H₂S is poisonous, and accidents may occur on exposure to natural gas, volcanic gas, and industrial waste. Accidents have been reported in sewage disposal facilities [2-5] and chemical processing plants [6-8], and with the ingestion of sulfur products [9,10]. H₂S is also produced naturally by the putrefaction of organic compounds. The gas produced by this process is unstable and is rapidly metabolized as thiosulfate and sulfate by hepatic oxidation, therefore, quantifying the original substances is difficult [11,12]. Fatalities by H₂S poisoning are encountered frequently in the forensic

practices. There is a large amount of sulfate in the blood and urine of healthy people, whereas the thiosulfate content is very low [11,13]. In addition, thiosulfate is a major metabolite of H_2S [11]. For these reasons, thiosulfate has been reported to be a useful indicator for H_2S exposure [2–4,11,14–17]. Here, we report a case of two patients who died almost simultaneously due to H_2S poisoning. In this case, the pathological and toxicological findings were different between the two patients. We compare the findings and discuss the variable biomechanisms of H_2S poisoning.

2. Case report

A large-sized cargo vessel, approximately 36,000 tons, which was in transit with a large quantity of sweet corn, was destroyed by breaking in two due to stranding in a gulf under a heavy typhoon. The stranded cargo vessel was covered widely with a large amount of heavy oil that issued from

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the fuel tank. Accordingly, an operation was performed to eliminate the heavy oil inside and around the cargo vessel. At approximately one month after the accident, ten workers, including our two patients entered a water ballast tank to recover the remaining heavy oil. At 11:15 a.m., all of the workers suddenly felt unwell. Eight workers escaped by themselves from the tank with clouded consciousness. At 11:58 a.m., rescue personnel equipped with gas masks found collapsed patient A (male in his early thirties) sitting on a sloped floor and leaning on a wall. At 11:59 a.m., they found collapsed patient B (male in his early sixties) lying prone on a sloped floor. His head was located on the upper side of the sloped floor. Although a small amount of black sludge had collected on the bottom of the sloped floor, the nose and mouth of both patients were not submerged in the sludge. Rescue personnel retrieved patient A from the tank at 0:04 p.m. and patient B at 0:16 p.m. The patients arrived at a hospital at 0:59 p.m. in a state of cardiopulmonary arrest. They were pronounced dead at 1:03 p.m. (patient A) and 1:04 p.m. (patient B), respectively. After using an electric fan to remove the harmful gas from the tank and about 4 h after the accident, the air concentration of H2S, oxygen (O2), and carbon monoxide (CO) at the scene were estimated to be 30 ppm, 20.8% and 355 ppm, respectively. Autopsies on patient A and B were performed at 20 and 24 h after death, respectively.

3. Autopsy findings

3.1. Patient A

Patient A was a male in his early thirties. He was 169 cm in height and 68 kg in weight. A slight greenish discolor-

ation presented on his anterior cervical region and precordia. A few black subcutaneous bleedings were observed on regions of back and upper and lower limbs. The palpebral conjunctiva and the mucous membrane of the mouth revealed marked hyperemia and a few petechiae. The ocular conjunctiva revealed marked hyperemia, but was free of petechiae. The heart weighed 330 g, and a large amount of black dark-red fluid blood was retained in the heart. The left and right lungs weighed 830 and 925 g, respectively, with marked swelling and congestion. There was a little dark brown-red mucous fluid mixed with the micro foam in the trachea and bronchia. The mucous membrane of the glottis, trachea and bronchia revealed extensive erosion and submucosal hemorrhage (Fig. 1A). Extensive erosion and submucous hemorrhages were seen in the entire inner membrane of the esophagus. Erosion was found in the posterior wall of the fundus ventriculi and the cardia of the lesser curvature of the stomach. The lumen of the small intestine revealed congestion and localized erosion. The liver and the spleen weighed 1800 and 120 g, respectively, and both organs revealed no remarkable changes except for congestion. The brain weighed 1480 g, and slight cerebral edema was noted. There were no remarkable findings in other organs except for congestion.

Histological examination revealed marked congestion and edema in both lungs. Marked congestion, erosion and submucosal hemorrhage, as well as edema of the tunica propria and tela submucosa were observed in the epiglottis, glottis vocalis (Fig. 2A), trachea and bronchia. Similar findings were observed in the esophagus and stomach. Severe necroses were noted in the tracheal and bronchial glands. No remarkable changes, except for congestion, were found in other organs including the liver.

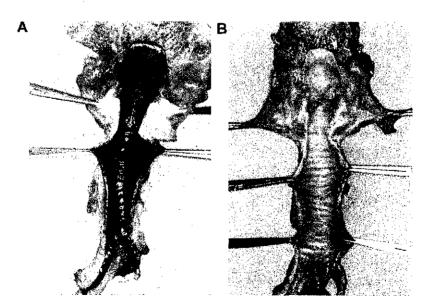


Fig. 1. The trachea of patient A (A) and B (B). The mucous of patient A reveals extensive erosion and the submucous bleeding, whereas the mucous of patient B reveals hyperemia, but is free of erosion.

Attachment

6

General Affidavit

| STATE OF TEXAS |
|--|
| COUNTY OF Harr'S |
| BEFORE ME, the undersigned Notary, <u>Juanita Thomas</u> , on this, day of, 2009, personally appeared |
| known to me to be a credible person and of lawful age, who being by me duly |
| sworn, on his oath, deposes and says: |
| "My name is Matt Bowman. I am over 21 years of age. I was the President on December 18, 2008, at the Port Arthur Chemical and Environmental Services, LLC ("PACES") plant site at the time Joey Sutter passed away. I have personal knowledge of the PACES operations. During the morning and afternoon of December 18, 2008, Trailer 267 was not heated with steam or any other source of heat. Steam was not available." |
| (Signature of Affiant) |
| Matt Bowman (Printed Name of Affiant) (b) (4) (Home Address) |
| (City, State & Zip) |
| STATE OF TEXAS COUNTY OF Harris |
| Sworn to and subscribed before me on this <u>22</u> day of <u>May</u> , 2009, by <u>MATI BOWMAN</u> . |
| JUANITA IROMAS Notary Public, State of Texas My Commission Expires May 24, 2009 May 24, 2009 May 24, 2009 |

Attachment

7

General Affidavit

| STATE OF TEXAS |
|--|
| COUNTY OF Jufuson |
| BEFORE ME, the undersigned Notary, TATRICIA GRACE Krug, on this |
| day of March, 2009, personally appeared Suzie Mock |
| known to me to be a credible person and of lawful age, who being by me duly |
| sworn, on her oath, deposes and says: |
| My name is Suzie Mock. I am over 21 years of age. I was an employee on December 18, 2008 at the Port Arthur Chemical and Environmental Services, LLC ("PACES") plant site at the time Joey Sutter passed away. I have personal knowledge and experience with the situation during the incident involving Joey Sutter. During the morning and afternoon of December 18, 2008 my personal monitor for the H ₂ S did not sound an alarm warning. My personal H ₂ S Monitor Alarm was set at 10 ppm for H ₂ S on December 18, 2008. |
| Suz moul |
| (Signature of Affiant) |
| Suzie Mock (Printed Name of Afficial) |
|) (4) |
| (Address of Affiant, Line 1) |
| |
| (Address of Affiant, Line 2) |
| STATE OF TEXAS |
| COUNTY OF Jefferson |
| Sworn to and subscribed before me on this 310 day of March, 2009, |
| by |
| |
| SEAL TOTALES PLACE KINES |
| Patricia Grace Kruger Notary Public Signature) Notary Public Signature) Notary Public Signature) Notary Public Signature) |

Attachment

8



NMS Labs

3701 Weish Road, PO Box 433A, Willow Grove, PA 19090-0437
Phone: (215) 557-4900 Fax: (215) 557-2972
e-mail: nma@nmslabs.com
Robert A. Middleberg, PhD, DABFT, DABGC-TC, Laboratory Director

Toxicology Report

Report Issued 01/20/2009 17:00

To:

10240

Southeast Texas Forensic Ctr.-Beaumont

Attn: Dr. Tommy Brown

5030 Highway 69 South, Ste.700

Beaumont, TX 77705

Patient Name Patient ID Chain

Age Gender Workorder

Page 1 of 2

b) (4) 10973749

Not Given
Male
09009238

APR 7 2 2009

Justice court, Pct. 8

FILED

Positive Findings:

| Compound | Result | Units | Matrix Source | |
|------------------------------------|--------------|-----------------|-----------------|---|
| Creatinine Thiosuffate | _1959 3.4 | .mg/L mog/mL | -Urine Urine | |
| Thiosulfate (Creatinine corrected) | 1.7 | mcg/g Creat | Urine | · |

See Detailed Findings section for additional information

Specimens Received:

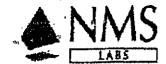
| ID T | ube/Container | Volume/ Mass | Collection Date/Time | Matrix Source | Miscellaneous Information |
|--------|---------------|-----------------|-------------------------|---------------|------------------------------|
| | ray Top Tube | 10.75 mL | Not Given | Blood | |
| UU2 KE | ed Top Tube | 9.75 mL | Not Given | Urine | |

All sample volumes/weights are approximations,

Specimens received on 01/15/2009.

Testing Requested:

| Analysis Code | Description |
|--------------------|-----------------------|
| 4235B | Sulfhemoglobin, Blood |
| 4472L) | Thiosulfate, Urine |



CONFIDENTIAL

Workorder Chain Patient ID 09009238 10973749 b) (4)

Page 2 of 2

Detailed Findings:

| Analysis and Comments | Result | Units | Apt. Limit | Specimen Source | Analysis By |
|------------------------------------|--------|-------------|---------------|-----------------|-------------|
| Creatinine | 1959 | mg/L | 5.0 | 002 - Urine | Colorimetry |
| Thiosulfate | 3.4 | mcg/mL | 1.0 | 002 - Urine | IC |
| Thiosulfate (Creatinine corrected) | 1.7 | mcg/g Creat | 0.51 | 002 - Urine | IC |

Other than the above findings, examination of the specimen(s) submitted did not reveal any positive findings of toxicological significance by procedures outlined in the accompanying Analysis Summary.

Reference Comments:

Creatinine - Urine:

ACGIH Normal range in adulta: 300 - 3400 mg/L (mean: 1000 mg/L) [0:3 - 3.4 g/L (mean: 1 g/L)] 1000 - 1600 mg/day (1.0 - 1.6 g/day).

2. Thiosulfate - Urine:

Thiosulfate is a byproduct of the metabolic degradation of cysteine and methionine. As a result, normal endogenous levels of thiosulfate can be found in urine. However, whether normal levels of thiosulfate can be found in serum, plasma or whole blood is debatable. Certain environmental exposures, dietary conditions and pathological states can give rise to increased urinary levels of thiosulfate as well as significant concentrations in serum, plasma and/or whole blood. Hydrogen sulfide exposure is a common source of increased urinary and serum levels of thiosulfate.

Reported endogenous thiosulfate levels in unne range from 1 - 5 mcg/mL.

3. Thiosulfate (Creatinine corrected) - Urine:

Normal: Up to 8 mcg/g Creatinine. 15 hours after a 60 minute exposure to air concentrations of 60 micromoles/L Hydrogen Sulfide resulted in urine concentrations up to 60 mcg/g Creatinine.

This analysis was performed under chain of custody after receipt at NMS Labs. The chain of custody documentation is on file at NMS Labs.

Unless alternate arrangements are made by you, the remainder of the submitted specimens will be discarded six (6) weeks from the date of this report; and generated data will be discarded five (5) years from the date of this report.

Analysis Summary:

Acode 4235B - Sulfhemoglobin, Blood

- Analysis by Spectrophotometry (SP) for: Sulfhemoglobin

Acode 4472U - Thiosulfate, Urine

- Analysis by Colorimetry (C) for: Creatinine
- Analysis by Ion Chromatography (IC) for Thiosulfate, Thiosulfate (Creatinine corrected)

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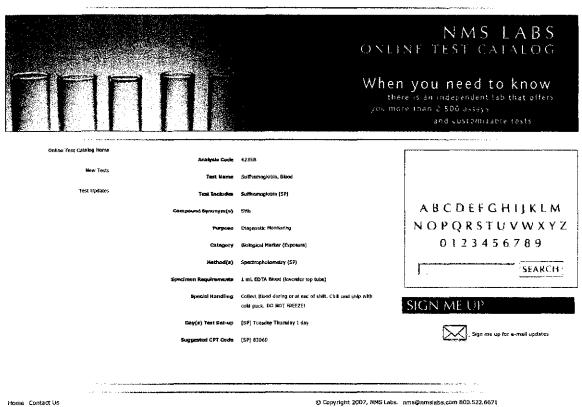
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Display AbstractPlus

4/30/2009







Heart Conditions

High Blood Pressure (Hypertension)

Hypertension, the medical term for high blood pressure, is known as "the silent killer." At least 73 million Americans have high blood pressure, and as many as 20 million of them do not even know they have the condition. If left untreated, high blood pressure greatly increases your risk for heart attack and stroke.

Your heart pumps blood through a network of arteries, veins, and capillaries. The moving blood pushes against the arterial walls, and this force is measured as blood pressure.

High blood pressure results from the tightening of very small arteries called arterioles. Arterioles regulate the blood flow through your body. As these arterioles tighten (or constrict), your heart

Be heart-smart about high blood pressure.



- How does high blood pressure affect health?
- What are the causes?
- How is it diagnosed?
- How high is high?
- How is it treated?

Your Guide to Lowering High Blood Pressure

has to work harder to pump blood through the smaller space, and the pressure inside the vessels grows.

High blood pressure can affect your health in four main ways:

- Hardening of the arteries. Pressure inside your arteries can cause the
 muscles that line the walls of the arteries to thicken. Thickening causes
 the arteries to narrow. A heart attack or stroke can occur if a blood clot
 blocks blood flow to your heart or brain.
- **Enlarged heart.** High blood pressure increases the amount of work for your heart. Like any heavily exercised muscle in your body, your heart grows bigger. The bigger your heart is, the less able it is to maintain proper blood flow. As a result, you feel weak and tired and are not able to exercise or perform physical activities. Your heart has begun to fail. Without treatment, your heart failure will only get worse.
- **Kidney damage.** Prolonged high blood pressure can damage your kidneys if the arteries supplying your kidneys with blood are affected.
- **Eye damage.** If you have diabetes, high blood pressure can cause the tiny capillaries in the retina of your eye to bleed. This condition, called retinopathy, can lead to blindness.

What causes high blood pressure?

http://texasheart.org/HIC/Topics/Cond/hbp.cfm?&RenderForPrint=1

About 90% to 95% of all high blood pressure cases are what is called **primary**, or **essential hypertension**. That means the real cause of the high blood pressure is not known, but a number of factors are associated with the condition. You are at an increased risk of high blood pressure if you

- Have a family history of high blood pressure.
- Are African American. African Americans develop high blood pressure more often than whites, and it tends to happen earlier in life and be more severe.
- Are male. Women are at an increased risk after age 55.
- Are older than 60. Blood vessels become more brittle with age and are not as flexible.
- Face high levels of stress. In some studies, stress, anger, hostility, and
 other personality traits have been shown to lead to high blood pressure,
 but the findings have not always been consistent. Emotional factors most
 likely add to the risk of high blood pressure for people who also have
 other risk factors.
- Are overweight or obese.
- Use tobacco products. Smoking damages your blood vessels.
- Use oral contraceptives. Women who smoke and use oral contraceptives greatly increase their risk.
- · Eat a diet high in saturated fat.
- Eat a diet high in salt (sodium).
- Drink more than a moderate amount of alcohol. Experts say that
 moderate intake is an average of one to two drinks per day for men and
 one drink per day for women. One drink is defined as 1½ fluid ounces (fl
 oz) of 80-proof spirits (such as bourbon, Scotch, vodka, gin, etc.), 1 fl oz
 of 100-proof spirits, 4 fl oz of wine, or 12 fl oz of beer.
- Are physically inactive.
- Have diabetes.

Researchers have also found a gene that appears to be linked to high blood pressure. If you have the gene, it does not mean that you or your children will develop high blood pressure. But it does mean that you are more likely to develop high blood pressure, so your blood pressure should be closely watched.

The remaining patients with high blood pressure have what is called **secondary hypertension**. Secondary hypertension means that the high blood pressure is the result of another condition or illness. Many cases of secondary hypertension are caused by kidney disorders. Other conditions that can cause secondary hypertension are

- Problems with the parathyroid gland.
- Acromegaly, which is a condition where the pituitary gland makes too much growth hormone.
- Tumors in the adrenal or pituitary glands.
- Reactions to medicines for other medical problems.
- Pregnancy.

What are the symptoms of high blood pressure?

Most people who have high blood pressure usually do not have symptoms. In some cases, people with high blood pressure may have a pounding feeling in their head or chest, a feeling of lightheadedness or dizziness, or other signs. If

http://texasheart.org/HIC/Topics/Cond/hbp.cfm?&RenderForPrint=1

there are no warning signs, people with high blood pressure may go years without knowing they have the condition.

How is high blood pressure diagnosed?

A visit to your doctor is the only way to find out if you have high blood pressure. You should have a general medical check-up that includes a review of your family's medical history. Your doctor will take several blood pressure readings using a device called a sphygmomanometer and run a few routine tests.

Your doctor may also use a device called an ophthalmoscope to look at the blood vessels in your eyes. Doctors can see if these vessels have thickened, narrowed, or burst, which may be a sign of high blood pressure. Your doctor will also use a stethoscope to listen to your heart and the sound of blood flowing through your arteries. In some cases, a chest x-ray and electrocardiogram may be needed.

Blood pressure readings

Blood pressure readings measure the two parts of blood pressure: systolic and diastolic pressures. Systolic pressure is the force of blood flow through an artery when the heart beats. Diastolic pressure is the force of blood flow within blood vessels when the heart rests between beats.

A blood pressure reading measures both the systolic and diastolic forces, with the systolic pressure listed first. The numbers show your pressure in units of millimeters of mercury (mm Hg)—how high the pressure inside your arteries would be able to raise a column of mercury. For example, a reading of 120/80 mm Hg means a systolic pressure of 120 mm Hg and diastolic pressure of 80 mm Hg.

Most doctors do not make a final diagnosis of high blood pressure until they measure your blood pressure several times (at least 2 blood pressure readings on 3 different days). Some doctors ask their patients to wear a portable machine that measures their blood pressure over the course of several days. This machine may help the doctor find out whether a patient has true high blood pressure or what is known as "white-coat hypertension." White-coat hypertension is a condition in which a patient's blood pressure rises during a visit to a doctor, but not at other times. Although doctors are not sure what causes white-coat hypertension, anxiety and stress probably play a role.

How often should blood pressure be checked?

Adults should have their blood pressure checked at least once a year. Many grocery or drug stores have blood pressure machines that you can use for free any time you visit the stores. Keep in mind, though, that these machines may not give you a correct reading.

Blood pressure monitors for use at home can be bought at drug stores, department stores, and other places. Again, these monitors may not always give you a correct reading. You should always compare your machine's reading

http://texasheart.org/HIC/Topics/Cond/hbp.cfm?&RenderForPrint=1

with a reading from your doctor's machine to make sure they are the same. Remember that any measurement above normal should prompt a visit to the doctor, who can then talk with you about the best course of action.

How high is high?

According to new guidelines released by the National Heart, Lung, and Blood Institute (NHLBI) in 2003, a reading below 120/80 mm Hg is now classified as normal blood pressure. Those with a blood pressure reading anywhere from 120/80 up to 139/89 (once thought to be normal) are now classified within a category called "prehypertension." The NHLBI says that about 45 million Americans fall within the prehypertension category, which puts them at twice the risk of developing high blood pressure later in life.

Blood Pressure Classification Chart

| Category | Systolic (mm Hg) | Diastolic (mm Hg) |
|-----------------|------------------|-------------------|
| Normal | Lower than 120 | Lower than 80 |
| Prehypertension | 120 - 139 | 80 - 89 |

Hypertension

Stage 2 160 or higher 100 or higher

Adapted from The Seventh Report on the joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7), NIH Publication No. 03-5233, May 2003

The classification chart is based on adults, aged 18 and older, who are not taking high blood pressure medicines and who are not acutely ill. If systolic and diastolic measurements fall into different categories, the higher category should be used to classify the person's blood pressure status.

How is high blood pressure treated?

The first course of action usually involves lifestyle changes, especially for people with prehypertension.

- Start eating a low-fat and low-salt diet.
- Lose weight, if you need to.
- · Begin a regular exercise program.
- · Learn to manage stress.
- If you smoke, quit.
- Drink alcohol in moderation, if at all. Remember that moderate intake is an average of one or two drinks per day for men and one drink per day for women.

Medicines are available if these changes do not help control your blood pressure within 3 to 6 months. Diuretics help rid your body of water and sodium. ACE inhibitors block the enzyme that raises your blood pressure. Other types of medicines— beta blockers, calcium channel blockers, and other vasodilators— work in different ways, but their overall effect is to help relax and widen your

http://texasheart.org/HIC/Topics/Cond/hbp.cfm?&RenderForPrint=1

blood vessels and reduce the pressure inside the vessel.

See also on this site:

- Congestive Heart Failure
- Heart Attack Warning Signs
- Stroke
- "Recognizing Hypertension and its Symptoms in Children" (presentation available in the Project Heart subsite)



Does managing blood pressure have to be this hard?

See on other sites:

Visit the National Heart, Lung, and Blood Institute: Your Guide to Lowering High Blood Pressure.

Download an HBP Wallet Card.

Browse the NHLBI's Keep the Beat: Heart-Healthy Recipe Book.

MedlinePlus www.nlm.nih.gov/medlineplus/highbloodpressure.html High Blood Pressure

Updated Feburary 2009

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Enlarged heart

By Mayo Clinic staff

Original Article:http://www.mayoclinic.com/health/enlarged-heart/DS01129/DSECTION=causes

Definition

Enlarged heart (cardiomegaly) isn't a disease, but rather a symptom of another condition.

The term "cardiomegaly" most commonly refers to an enlarged heart seen on chest X-ray before other tests are performed to diagnose the specific condition causing your enlarged heart. You may develop an enlarged heart temporarily because of a stress on your body, such as pregnancy, or because of a medical condition, such as the weakening of the heart muscle, coronary artery disease, heart valve problems or abnormal heart rhythms.

While having an enlarged heart may not always be preventable, it's usually treatable. Treatment for enlarged heart is aimed at correcting the underlying cause. Treatment for an enlarged heart can include medications, medical procedures or surgery.

Symptoms

In some people, an enlarged heart causes no signs or symptoms. Others may have these enlarged heart symptoms:

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- Breathing difficulties
- Shortness of breath
- Dizziness
- Abnormal heart rhythm (arrhythmia)
- Swelling (edema)
- Cough

When to see a doctor

Enlarged heart is easier to treat when it's detected early, so talk to your doctor about any concerns you have about your heart health. If you don't have an enlarged heart, but are concerned about developing the condition, talk to your doctor about steps you can take to reduce your risk.

If you think you may have a problem with your heart based on new signs or symptoms you've been having, make an appointment to see your doctor.

Seek emergency medical care if you have any of these signs and symptoms, which may mean you're having a heart attack:

- Chest pain
- Shortness of breath
- Fainting

Causes

Sometimes, an enlarged heart develops for no apparent reason (idiopathic) but it can also be caused by a condition that can cause your heart to pump harder than usual. These conditions can include:

- High blood pressure. Having high blood pressure can make it so that your heart has to pump harder to deliver blood to the rest of your body, enlarging the muscle.
- Heart valve disease. Four valves within your heart keep blood flowing in the right direction. If the valves are damaged by such conditions as

rheumatic fever, a heart defect, infections (infectious endocarditis), connective tissue disorders, certain medications or radiation treatments for cancer, your heart may enlarge.

- Weakness of the heart muscle (cardiomyopathy). Cardiomyopathy is the thickening and stiffening of heart muscle. In early stages of cardiomyopathy, you may have no symptoms. As the condition worsens, your heart may enlarge to try to pump more blood to your body.
- A heart condition you're born with (congenital heart defect). Many types of congenital heart defects may lead to an enlarged heart, as defects can affect blood flow through the heart, forcing it to pump harder.
- Abnormal heartbeat (arrhythmia). If you have an arrhythmia, your heart may not pump blood as effectively as it would if your heart rhythm were normal. The extra work your heart has to do to pump blood to your body may cause it to enlarge.
- High blood pressure in the artery connecting your heart and lungs (pulmonary hypertension). If you have pulmonary hypertension, your heart may need to pump harder to move blood between your lungs and your heart. As a result, the right side of your heart may enlarge.
- Low red blood cell count (anemia). Anemia is a condition in which there aren't enough healthy red blood cells to carry adequate oxygen to your tissues. Left untreated, chronic anemia can lead to a rapid or irregular heartbeat. Your heart must pump more blood to make up for the lack of oxygen in the blood when you're anemic. Rarely, your heart can enlarge if you have anemia for a long time and you don't seek treatment.
- Thyroid disorders. Both an underactive thyroid gland (hypothyroidism) and an overactive thyroid gland (hyperthyroidism) can lead to heart problems, including an enlarged heart.
- Excessive iron in the body (hemochromatosis). Hemochromatosis is a disorder in which your body doesn't properly use iron, causing it to build up in various organs, including your heart muscle. This can cause an enlarged left ventricle due to weakening of the heart muscle.
- Protein buildup in your heart (amyloidosis). Amyloidosis is a condition in which abnormal proteins circulate in the blood and may be deposited in the heart, interfering with your heart's function. If amyloid builds up in your heart, it can cause it to enlarge.

Risk factors

You may have a greater risk of developing an enlarged heart if you have any of the following risk factors:

- High blood pressure. Having a blood pressure measurement higher than 140/90 millimeters of mercury puts you at an increased risk of developing an enlarged heart.
- A family history of enlarged heart or cardiomyopathy. If an immediate family member, such as a parent or sibling, has had an enlarged heart, you may be more susceptible to developing an enlarged heart.
- Blocked arteries in your heart (coronary artery disease). If you have coronary artery disease, fatty plaques in the arteries of your heart make it so blood can't easily flow through the vessels of your heart. Your heart has to pump harder to get an adequate amount of blood to the rest of your body, causing it to enlarge.
- Congenital heart disease. If you're born with a condition that affects the structure of your heart, you may be at risk for developing an enlarged heart, especially if your condition isn't treated.
- Valvular heart disease. The heart has four valves the aortic, mitral, pulmonary and tricuspid valves that open and close to direct blood flow through your heart. Valves may be damaged by a variety of conditions leading to narrowing (stenosis), leaking (regurgitation or insufficiency) or improper closing (prolapse). Any of these conditions may cause the heart to enlarge.

Complications

The risk of complications from an enlarged heart depends on the part of the heart that is enlarged and the underlying cause. One of most serious types of enlarged heart is an enlarged left ventricle leading to the possibility of heart failure.

Heart failure. Heart failure occurs when your heart can't pump enough blood to meet your body's needs. Over time, the heart can no longer keep up with the normal demands placed on it. The heart muscle will weaken, and the ventricles stretch (dilate) to the point that the heart can't pump blood efficiently throughout your body.

Other complications of enlarged heart can include:

- Blood clots. Having an enlarged heart may make you more susceptible to forming small blood clots in the lining of your heart. If clots are pumped out of the heart and enter your circulatory system, they can block the blood flow to vital organs, including your heart and brain causing a heart attack or stroke. If clots develop on the right side of your heart, they may travel to your lungs, a dangerous condition called pulmonary embolism.
- Heart murmur. For people who have an enlarged heart, two of the heart's four valves the mitral and tricuspid valves may not close properly because they become dilated, leading to a backflow of blood. This flow creates sounds called heart murmurs. Heart murmurs are not necessarily harmful, but they should be monitored by your doctor.
- Cardiac arrest and sudden death. Some forms of enlarged heart can lead to disruptions in your heart's beating rhythm. Some of these heart rhythms are too slow to move your blood, and some are too fast to allow the heart to beat properly. In either case, these abnormal heart rhythms can result in fainting or, in some cases, cardiac arrest or sudden death.

Preparing for your appointment

If you think you may have an enlarged heart, or are worried about your heart disease risk because of a strong family history, make an appointment with your family doctor. If heart disease is found early, your treatment may be easier and more effective. Eventually, however, you may be referred to a heart specialist (cardiologist).

Because appointments can be brief, and because there's often a lot of ground to cover, it's a good idea to be prepared for your appointment. Here's some information to help you get ready for your appointment, and what to expect from your doctor.

What you can do

- Be aware of any pre-appointment restrictions. At the time you make the appointment, be sure to ask if there's anything you need to do in advance, such as restrict your diet. For a cholesterol test, for example, you may need to fast for a period of time beforehand.
- Write down any symptoms you're experiencing, including any that may seem unrelated to coronary artery disease.

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- Write down key personal information, including a family history of heart disease, stroke, high blood pressure or diabetes, and any major stresses or recent life changes.
- Make a list of all medications, as well as any vitamins or supplements that you're taking.
- Take a family member or friend along, if possible. Sometimes it can be difficult to soak up all the information provided to you during an appointment. Someone who accompanies you may remember something that you missed or forgot.
- Be prepared to discuss your diet and exercise habits. If you don't already follow a diet or exercise routine, be ready to talk to your doctor about any challenges you might face in getting started.
- Write down questions to ask your doctor.

Your time with your doctor is limited, so preparing a list of questions will help you make the most of your time together. List your questions from most important to least important in case time runs out. For enlarged heart, some basic questions to ask your doctor include:

- What is likely causing my symptoms or condition?
- What are other possible causes for my symptoms or condition?
- What kinds of tests will I need?
- What is the best course of action?
- What foods should I eat or avoid?
- What's an appropriate level of physical activity?
- How often should I be screened for heart disease? For example, how often do I need a cholesterol test?
- What are the alternatives to the primary approach that you're suggesting?
- I have other health conditions. How can I best manage them together?
- Are there any restrictions that I need to follow?

- Should I see a specialist?
- Should my children be screened for this condition?
- Is there a generic alternative to the medicine you're prescribing me?
- Are there any brochures or other printed material that I can take home with me? What Web sites do you recommend visiting?

In addition to the questions that you've prepared to ask your doctor, don't hesitate to ask questions during your appointment at any time that you don't understand something.

What to expect from your doctor

Your doctor is likely to ask you a number of questions. Being ready to answer them may reserve time to go over any points you want to spend more time on. Your doctor may ask:

- When did you first begin experiencing symptoms?
- Have your symptoms been continuous, or occasional?
- How severe are your symptoms?
- What, if anything, seems to improve your symptoms?
- What, if anything, appears to worsen your symptoms?

Tests and diagnosis

If you have symptoms of a heart problem, your doctor will perform tests to determine if your heart is enlarged and to find out the underlying cause of your condition. In addition to a physical exam, these tests may include:

- Chest X-ray. X-ray images help your doctor see the condition of your lungs and heart. If your heart is enlarged it might first be detected by a chest X-ray, but other tests will usually be needed to find out the specific cause. Your doctor can also use an X-ray to diagnose conditions other than enlarged heart that may explain your signs and symptoms.
- Electrocardiogram. This test records the electrical activity of your heart through electrodes attached to your skin. Impulses are recorded as waves

and displayed on a monitor or printed on paper. This test helps your doctor diagnose heart rhythm problems and damage to your heart from a heart attack as well as give clues to other types of heart disease.

- Echocardiogram. An important test for diagnosing and monitoring an enlarged heart is the echocardiogram. An echocardiogram uses sound waves to produce a video image of your heart. In this test all of the chambers of the heart can be evaluated to determine if you do have an enlarged heart and to try and determine the cause. This test determines how efficiently your heart is pumping, assesses your heart valves, can look for evidence of previous heart attacks and can determine if you have congenital heart disease.
- Cardiac computerized tomography (CT) or magnetic resonance imaging (MRI). Although more commonly used to check for heart failure, more doctors are using these tests to diagnose heart problems. In a cardiac CT scan, you lie on a table inside a doughnut-shaped machine called a gantry. An X-ray tube inside the machine rotates around your body and collects images of your heart and chest.

In a cardiac MRI, you lie on a table inside a long tube-like machine that produces a magnetic field. The magnetic field aligns atomic particles in some of your cells. When radio waves are broadcast toward these aligned particles, they produce signals that vary according to the type of tissue they are. Images of your heart are created from these signals, which your doctor will look at to determine the cause of your enlarged heart.

- Blood tests. Your doctor may order blood tests to check the levels of certain substances in your blood that may signal that you have an enlarged heart. Blood tests can also help your doctor rule out other conditions that may cause your symptoms.
- Cardiac catheterization and biopsy. In this procedure, a thin tube (catheter) is inserted in your groin and threaded through your blood vessels to your heart, where a small sample (biopsy) of your heart can be extracted for analysis in the laboratory. Pressure within the chambers of your heart can be measured to see how forcefully blood pumps through your heart. Pictures of the arteries of the heart can be taken during the procedure (coronary angiogram) to ensure that you do not have any blockage.

Treatments and drugs

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Enlarged heart treatment focuses on correcting the underlying condition.

Medications

If cardiomyopathy or another cause of a weak heart muscle is to blame for your enlarged heart, your doctor may recommend medications to treat heart failure symptoms. These include:

- **Diuretics** to lower the amount of sodium and water in your body, which can help lower the pressure in your arteries and heart, such as furosemide (Lasix), or other diuretics, such as spironolactone (Aldactone), which can help prevent further scarring of your heart tissue
- Angiotensin-converting enzyme (ACE) inhibitors to lower your blood pressure and improve your heart's pumping capability, such as enalapril (Vasotec), lisinopril (Zestril, Prinivil), ramipril (Altace) or captopril (Capoten)
- Angiotensin receptor blockers (ARBs), such as losartan (Cozaar) and valsartan (Diovan), for those who can't take ACE inhibitors
- Beta blockers to lower blood pressure and improve heart function, such as carvedilol (Coreg) and metoprolol (Lopressor, Toprol-XL)
- **Digoxin**, which can help improve the pumping function of your heart and lessen the need for hospitalization for heart failure

Medical procedures and surgeries

If medications aren't enough to treat your enlarged heart, medical procedures or surgery may be necessary.

Medical devices to regulate your heartbeat. For people who have a certain type of enlarged heart (dilated cardiomyopathy), a special pacemaker that coordinates the contractions between the left and right ventricle (biventricular pacing) may be necessary. In people who may be at risk of serious arrhythmias, drug therapy or an implantable cardioverter-defibrillator (ICD) may be options. ICDs are small devices — about the size of a box of matches — implanted in your chest to continuously monitor your heart rhythm and deliver electrical shocks when needed to control abnormal, rapid heartbeats. The devices can also work as pacemakers. If the main cause of your enlarged heart is due to atrial fibrillation, then you may need procedures to return your heart to regular rhythm or to keep your heart from beating too quickly.

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- Heart valve surgery. If your enlarged heart is caused by a problem with one of your heart valves, you may have surgery to remove the narrow valve and replace it with either an artificial valve or a tissue valve from a pig, cow or human-cadaver donor. If you have valve regurgitation, in which blood leaks backward through your valve, the leaky valve may be surgically repaired or replaced.
- Heart transplant. If medications can't control your symptoms, a heart transplant may be a final option. Because of the shortage of donor hearts, even people who are critically ill may have a long wait before having a heart transplant.

Lifestyle and home remedies

While you can't cure your enlarged heart with home remedies, there are some things you can do to improve your condition. Your doctor may recommend adopting the following lifestyle changes:

- Quit smoking.
- Lose excess weight.
- Eat a low-salt diet.
- Control diabetes.
- Monitor your own blood pressure.
- Get modest exercise, after discussing with your doctor the most appropriate program of physical activity.
- Eliminate or minimize the amount of alcohol you drink.
- Try to sleep eight hours each night.

Prevention

In most cases you can't prevent your heart from enlarging. Let your doctor know if you have a family history of conditions that can cause an enlarged heart, such as cardiomyopathy. If cardiomyopathy or other heart conditions are diagnosed early, treatments may prevent the disease from worsening.

You can help reduce your chance of developing heart failure by avoiding some of

the conditions that can contribute to a weak heart, including the abuse of alcohol or cocaine, or not getting enough vitamins and minerals. Controlling high blood pressure with diet, exercise, and possibly medications also prevents many people who have an enlarged heart from developing heart failure later in life. Controlling risk factors for coronary artery disease — tobacco use, high blood pressure, high cholesterol and diabetes — helps to reduce your risk of an enlarged heart and heart failure by reducing your risk of heart attack.

References

May 6, 2009 DS01129

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Attachment

9

Charles Brent Sittig

Attached is the incident report which states that Mr. Sittig was driving a tractor with a trailer loaded with Naphthenic caustic. The trailer was loaded for him at a refinery. Mr. Sittig drove to PACES and the material was unloaded without his help into Tank NV1. When Mr. Sittig died he was away from the trailer and Tank NVI with other people (e.g. Glen Olson). After Mr. Sittig died the material from NV1 was sampled and analysis of sulfides. The value measured by Set Environmental was less than 1 ppm for NV1(See Attachment). No alarms were triggered and No other people reported H2S exposure at the time of the death.

Report of Analysis

Page 1 of 1

Client Sample ID: (b) Lab Sample ID:

(142)7869-1 AQ - Water

Date Sampled: 04/15/09

Project:

Matrix:

CES

Date Received: 04/24/09 Percent Solids: n/a

General Chemistry

| Analyte | Result | MQL | SDL | Units | DF | Analyzed | Ву | Method |
|----------------------|--------|-----|------|-------|----|----------------|----|---------------|
| Hydroxide Alkalinity | 0.0300 | 5.0 | 0.66 | mg/l | i | 04/29/09 15:00 | | SM18 4500CO2D |
| Sulfide | 0.15 U | 8.0 | 0.15 | mg/l | 1 | 04/29/09 13:00 | | SM 4500S+F |

MQL = Method Quantitation Limit SDL = Sample Detection Limit

U = Indicates a result < SDL

B = Indicates a result > = SDL but < MQL



Attachment

10





Advancing the Possibilities'

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Hydrogen Sulfide Gas Shows Promise for Treating Heart Failure

November 11, 2008

At low concentrations, the toxic gas hydrogen sulfide protects the hearts of mice from heart failure, scientists at Emory University School of Medicine have found.

Their findings, presented Nov. 11 at the American Heart Association (AHA) Scientific Sessions conference in New Orleans, suggest that doctors could use hydrogen sulfide to treat humans with heart failure.



Best known for its rotten-egg smell, hydrogen sulfide can pose a deadly threat to miners or sewer workers. However, scientists have recently found that enzymes within the body produce the gas in small, physiological amounts, with multiple beneficial effects such as regulating blood pressure and attenuating inflammation.

David Lefer, PhD, professor of surgery at Emory University School of Medicine, and his team created a model of heart failure in mice by blocking their left coronary arteries either temporarily for an hour or permanently, causing part of their heart muscles to dle. Hydrogen sulfide was administered intravenously once a day for a week.

John Calvert, PhD, assistant professor of surgery working with Lefer, will present the findings at the AHA Meeting. "Our results show that hydrogen sulfide can blunt the impact of heart failure on heart function and mortality in a mouse model of heart failure," Calvert says.

Four weeks after artery blockage, mice treated with hydrogen sulfide had an ejection fraction, a measure of heart function, about a third larger than controls (36 compared to 27 percent). He and his colleagues also found similar effects in mice engineered to make more of an enzyme that generates hydrogen sulfide.

Heart failure, a leading cause of hospitalization for the elderly, describes a situation when the heart muscle cannot pump enough blood to meet the body's needs. Previous injury to the heart muscle from a heart attack, obesity, diabetes or high blood pressure all are contributing factors.

In a separate presentation, Calvert presented experimental data on how hydrogen sulfide works in the heart. The gas appears to stimulate heart muscle cells to produce their own antioxidants and molecules that stave off programmed cell death, a response to the loss of blood flow.

Both Calvert and Lefer are based at Carlyle Fraser Heart Center at Emory Crawford Long Hospital in Atlanta. Some of the research was performed at Albert Einstein College of Medicine in New York, with Susheel Gundewar, Saurabh Jha and John Elrod.

The research was funded by the National Institutes of Health, the American Diabetes Association and by a research grant from the biotechnology firm Ikaria Holdings. Lefer is a paid consultant for Ikaria, which is developing technology for hydrogen sulfide delivery.

About Emory Heart & Vascular Center

Emory Heart & Vascular Center doctors are committed to providing clinically excellent cardiovascular patient care, ploneering innovative clinical research and training the best heart specialists in the world. A component of Emory Healthcare, the Center is consistently recognized by U.S. News & World Report as one of the top heart centers in the country. Emory Healthcare is the clinical arm of Emory University's Woodruff Health Sciences Center and is the largest, most comprehensive health care system in Georgia.

http://www.emoryhealthcare.org/news_events/feature20081111b.html

5/7/2009



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OSHA's Form 301 Injuries and Illnesses Incident Report

Attention: This form contains information relating to employee health and must be used in a menner that protects the confidentiality of employees to the extent possible while the information is being used for occupational satety and health purposes.

U.S. Department of Labor

Occupational Safety and Health Administration

Form approved OMB no. 1218-0176

| | | | Form approved OMB no. 1218-0176 |
|---|---|-----|---|
| | Information about the employee | | Information about the case |
| This Injury and Illness Incident Report is one of the | Full Name Joaquinn Ramirez Alvarez | 10) | Case number from the Log1 (Transfer the case number from the Log after you record the case.) |
| first forms you must fill out when a recordable work- related injury or illness has occurred. Together with | 2) Street (h) (4) | 11) | Date of injury or illness 1/24/2008 |
| the Log of Work-Related injuries and Illnesses and the accompanying Summary, these forms help the | City State 2ip 2ip | 12) | Time employee began work5:00 AM_ AM/PM |
| employer and OSHA develop a picture of the extent and severity of work-related incidents. | 3) Date of birth | 13) | Time of event 11:30 AM AM/PM Check if time cannot be determined |
| Within 7 calendar days after you receive information that a recordable work-related injury or illness has occurred, you must fill out this form or an | 4) Date hired | 14) | What was the employee doing just before the incident occurred? Describe the activity, as well as the tools, equipment or material the employee was using. Be specific. Examples: "climbing a ladder white carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key-entry." |
| equivalent. Some state workers' compensation, insurance, or other reports may be acceptable | Female | | Cleaning tank |
| substitutes. To be considered an equivalent form, any substitute must contain all the information asked for on this form. According to Public Law 91-596 and 29 CFR 1904, OSHA's recordkeeping rule, you must keep this form on file for 5 years following the year to which it pertains If you need additional copies of this form, you may photocopy and use as many as you need. | Information about the physician or other health care professional 6) Name of physician or other health care professional Dr. Alan Rechter 7) If treatment was given away from the worksite, where was it given? | 15) | What happened? Tell us how the injury occurred. Examples: "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was spayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time." When ladder broke, worker fell ~10 feet. |
| | Facility Memorial Hermann Street 6411 Fannin | 16) | What was the injury or illness? Tell us the pert of the body that was affected and how it was affected; be more specific than "hurt", "pain", or "sore." Examples: "strained back"; "chemical burn, hend"; "carpal tunnel syndrome." Experienced pain in hip, wrist, and hand. |
| | City Houston State TX Zip 77030 | | experienced pain in hip, which and hards. |
| Completed by Prabhakar R. Thangudu Title HSE Manager | 8) Was employee treated in an emergency room? X Yes No 9) Was employee hospitalized overnight as an in-patient? | 17) | What object or substance directly harmed the employee? Examples: "concrete floor"; "chlorine"; "radial arm saw." If this question does not apply to the incident, leave it blank. Concrete floor |
| Phone 713-676-1460 Date 1/25/2008 | X Yes No | 18) | If the employee died, when did death occur? Date of death N/A |

Public reporting burden for this collection of information is estimated to average 22 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information unless it displays a current valid OMB control number. If you have any comments about this estimate or any other aspects of this data collection, including suggestions for reducing this burden, contact: US Department of Labor, OSHA Office of Statistics, Room N-3644, 200 Constitution Ave, NW, Washington, DC 20210. Do not send the completed forms to this office.

OSHA's Form 301 Injuries and Illnesses Incident Report

X No

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

18) If the employee died, when did death occur? Date of death

U.S. Department of Labor

Occupational Safety and Health Administration

Form approved OMB no. 1218-0176

Information about the employee Information about the case Sebastian McCrimmons 10) Case number from the Log (Transfer the case number from the Log after you record the case.) This Injury and Illness Incident Report is one of the first forms you must fill out when a recordable work-Date of injury or illness related injury or illness has occurred. Together with the Log of Work-Related injuries and Illnesses and Time employee began work 6:00 AM/PN the accompanying Summary, these forms help the employer and OSHA develop a picture of the extent AM/PM x Check if time cannot be determined Date of birth Time of event and severity of work-related incidents. 4) Date hired What was the employee doing just before the incident occurred? Describe the activity, as well as Within 7 calendar days after you receive the tools, equipment or material the employee was using. Be specific. Examples: "climbing a ladder information that a recordable work-related injury or 5) X Male while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key-entry." illness has occurred, you must fill out this form or an equivalent. Some state workers' compensation. insurance, or other reports may be acceptable Unloading spent caustic substitutes. To be considered an equivalent form. Information about the physician or other health care professional any substitute must contain all the information What happened? Tell us how the injury occurred. Examples: "When ladder slipped on wet floor, worker asked for on this form. According to Public Law 91-596 and 29 CFR 6) Name of physician or other health care professional fell 20 feet": "Worker was spayed with chlorine when gasket broke during replacement": "Worker developed soreness in wrist over time." 1904, OSHA's recordkeeping rule, you must keep Dr. Jean Dolan Employee sprayed with caustic this form on file for 5 years following the year to which it pertains If you need additional copies of this form, you 7) If treatment was given away from the worksite, where was it given? may photocopy and use as many as you need. What was the injury or illness? Tell us the part of the body that was affected and how it was affected: Facility Concentra Medical Centers be more specific than "hurt", "pain", or "sore." Examples: "strained back": "chemical burn, hand": "carpal 10909 East Frwy tunnel syndrome." Head and face sprayed with caustic State TX Zip 77029 8) Was employee treated in an emergency room? Completed by Prabhakar R. Thangudu Yes What object or substance directly harmed the employee? Examples: "concrete floor"; "chlorine"; "radial arm saw." If this question does not apply to the incident, leave it blank x No HSE Manager 9) Was employee hospitalized overnight as an in-patient? Phone <u>713-676-</u>1460 Yes

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Phone 713-676-1460

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Occupational Safety and Health Administration

Form approved OMB no. 1218-0176

Information about the employee Information about the case Farrier Riley 10) Case number from the Log (Transfer the case number from the Log after you record the case.) This Injury and Illness Incident Report is one of the first forms you must fill out when a recordable work-11) Date of injury or illness 5/22/2008 related injury or illness has occurred. Together with the Log of Work-Related injuries and Illnesses and State ____Zip Time employee began work 5:00 AM AM/PM the accompanying Summary, these forms help the employer and OSHA develop a picture of the extent 4:15 PM AM/PM Check if time cannot be determined 3) Date of birth Time of event and severity of work-related incidents. Within 7 calendar days after you receive 4) Date hired What was the employee doing just before the incident occurred? Describe the activity, as well as information that a recordable work-related injury or the tools, equipment or material the employee was using. Be specific. Examples: "climbing a ladder 5) x Male while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key-entry." illness has occurred, you must fill out this form or an equivalent. Some state workers' compensation, Leaving premises insurance, or other reports may be acceptable Information about the physician or other health care substitutes. To be considered an equivalent form, any substitute must contain all the information professional What happened? Tell us how the injury occurred. Examples: "When ladder slipped on wet floor, worker asked for on this form. According to Public Law 91-596 and 29 CFR 6) Name of physician or other health care professional fell 20 feet"; "Worker was spayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time." 1904, OSHA's recordkeeping rule, you must keep Worker caught between gate and a vehicle this form on file for 5 years following the year to which it pertains If you need additional copies of this form, you 7) If treatment was given away from the worksite, where was it given? may photocopy and use as many as you need. Facility Clear Lake Regional What was the injury or illness? Tell us the part of the body thet was affected and how it was affected; be more specific than "hurt", "pain", or "sore." Examples: "strained back"; "chemical burn, hand"; "carpal 10970 Shadow Creek Ranch Parkway tunnel syndrome." Cuts and bruises State __TX_ Zip _______77584 8) Was employee treated in an emergency room? Completed by Prabhakar R. Thangudu Yes 17) What object or substance directly harmed the employee? Examples: "concrete floor"; "chlorine"; "radial arm saw." If this question does not apply to the incident, leave it blank. HSE Manager Gate and vehicle

Public reporting burden for this collection of information is estimated to average 22 minutes per response, including time for reviewing instructions, searching existing data sources, gethering and maintaining the data needed, and completing and reviewing the collection of information unless it displays a current valid OMB control number. If you have any comments about this estimate or any other espects of this data collection, including suggestions for reducing this burden, contact: US Department of Labor, OSHA Office of Statistics, Room N-3644, 200 Constitution Ave, NW, Washington, DC 20210. Do not send the completed forms to this office.

9) Was employee hospitalized overnight as an in-patient?

Yes

OSHA's Form 301 Injuries and Illnesses Incident Report

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

U.S. Department of Labor

Occupational Safety and Health Administration

Form approved OMB no. 1218-0176

Information about the employee Information about the case Darryl L. Johnson Case number from the Log 5 (Transfer the case number from the Log after you record the case.) This Injury and Illness Incident Report is one of the first forms you must fill out when a recordable work-11) Date of injury or illness 8/6/2008 related injury or illness has occurred. Together with the Log of Work-Related injuries and Illnesses and Time employee began work 7:00 AM AM/PM the accompanying Summary, these forms help the AM/PM Check if time cannot be determined employer and OSHA develop a picture of the extent 3) Date of birth Time of event 11 AM and severity of work-related incidents. 4) Date hired What was the employee doing just before the incident occurred? Describe the activity, as well as Within 7 calendar days after you receive the tools, equipment or material the employee was using. Be specific. Examples: "climbing a ladder information that a recordable work-related injury or 5) X Male while carrying roofing materials": "spraying chlorine from hand sprayer": "daily computer key-entry." illness has occurred, you must fill out this form or an Female equivalent. Some state workers' compensation, Sampling insurance, or other reports may be acceptable Information about the physician or other health care substitutes. To be considered an equivalent form, professional any substitute must contain all the information What happened? Tell us how the injury occurred. Examples; "When ladder stipped on wet floor, worker asked for on this form. According to Public Law 91-596 and 29 CFR fell 20 feet"; "Worker was spayed with chlorine when gasket broke during replacement"; "Worker 6) Name of physician or other health care professional developed soreness in wrist over time." Dr. Oscal Rosales 1904, OSHA's recordkeeping rule, you must keep this form on file for 5 years following the year to which it pertains 7) If treatment was given away from the worksite, where was it given? If you need additional copies of this form, you may photocopy and use as many as you need. Memorial Herman Hospital What was the injury or illness? Tell us the part of the body that was affected and how it was affected: be more specific than "hurt", "pain", or "sore," Examples: "strained back"; "chemical burn, hand"; "carpal Street 6411 Fannin Street tunnel syndrome." Heat stress City State TX Zip 8) Was employee treated in an emergency room? Completed by Prabhakar R. Thangudu x Yes 17) What object or substance directly harmed the employee? Examples: "concrete floor"; "chlorine"; "radial arm saw." If this question does not apply to the incident, leave it blank. HSE Manager 9) Was employee hospitalized overnight as an in-patient? Phone 713-676-1460 x Yes ∏No 18) If the employee died, when did death occur? Date of death

Public reporting burden for this collection of information is estimated to average 22 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information unless it displays a current valid OMB control number. If you have any comments about this estimate or any other aspects of this data collection, including suggestions for reducing this burden, contact: US Department of Labor, OSHA Office of Statistics, Room N-3644, 200 Constitution Ave, NW, Washington, DC 20210. Do not send the completed forms to this office.

OSHA's Form 301 Injuries and Illnesses Incident Report

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the Information is being used for occupational safety and health purposes.

18) If the employee died, when did death occur? Date of death

U.S. Department of Labor

Occupational Safety and Health Administration

Form approved OMB no. 1218-0176

Information about the employee Information about the case 1) Full Name Scott Shimer 10) Case number from the Log 5 (Transfer the case number from the Log after you record the case.) This Injury and Illness Incident Report is one of the first forms you must fill out when a recordable work-11) Date of injury or illness related injury or illness has occurred. Together with State // Zip the Log of Work-Related injuries and Illnesses and Time employee began work the accompanying Summary, these forms help the 9:40 AM AM/PM Check if time cannot be determined employer and OSHA develop a picture of the extent Time of event 3) Date of birth and severity of work-related incidents. What was the employee doing just before the incident occurred? Describe the activity, as well as 4) Date hired Within 7 calendar days after you receive the tools, equipment or material the employee was using. Be specific. Examples: "climbing a ladder information that a recordable work-related injury or while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key-entry." 5) x Male illness has occurred, you must fill out this form or an equivalent. Some slate workers' compensation, Female Demonstrating to load roll-off truck on to a tractor insurance, or other reports may be acceptable Information about the physician or other health care substitutes. To be considered an equivalent form, professional any substitute must contain all the information 15) What happened? Tell us how the injury occurred. Examples: "When ladder slipped on wet floor, asked for on this form. According to Public Law 91-596 and 29 CFR 6) Name of physician or other health care professional worker fell 20 feet"; "Worker was spayed with chlorine when gasket broke during replacement"; "Worker developed screness in wrist over time." 1904, OSHA's recordkeeping rule, you must keep this form on file for 5 years following the year to Memoriel Herman Hospital which it pertains 7) If treatment was given away from the worksite, where was it given? If you need additional copies of this form, you may photocopy and use as many as you need. What was the injury or illness? Tell us the part of the body that was affected and how it was affected; be more specific than "hurt", "pain", or "sore." Examples: "strained back"; "chemical burn, hand"; Street Memorial Herman Hospital "carpal tunnel syndrome." cut City State TX Zip ____ 8) Was employee treated in an emergency room? 17) What object or substance directly harmed the employee? Examples: "concrete floor"; "chlorine"; Completed by Prabhakar R. Thangudu x Yes "radial arm saw." If this question does not apply to the incident, leave it blank. No HSE Manager raller 9) Was employee hospitalized overnight as an in-patient? Phone 713-676-1460 Yes

Public reporting burden for this collection of information is estimated to average 22 minutes per response, including time for reviewing the for reviewing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information unless it displays a current valid OMB control number. If you have any comments about this estimate or any other aspects of this data collection, including suggestions for reducing this burden, contact: US Department of Labor, OSHA Office of Statistics, Room N-3644, 200 Constitution Ave, NW, Washington, DC 20210. Do not send the completed forms to this office.

OSHA's Form 301 Injuries and Illnesses Incident Report

Information about the employee

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

information about the case

U.S. Department of Labor

Occupational Safety and Health Administration

Form approved OMB no. 1218-0176

This Injury and Illness Incident Report is one of the first forms you must fill out when a recordable work-related injury or illness has occurred. Together with the Log of Work-Related injuries and Illnesses and the accompanying Summary, these forms help the employer and OSHA develop a picture of the extent and severity of work-related incidents.

Within 7 calendar days after you receive information that a recordable work-related injury or illness has occurred, you must fill out this form or an equivalent. Some state workers' compensation, insurance, or other reports may be acceptable substitutes. To be considered an equivalent form, any substitute must contain all the information asked for on this form.

According to Public Law 91-596 and 29 CFR 1904, OSHA's recordkeeping rule, you must keep this form on file for 5 years following the year to which it pertains

If you need additional copies of this form, you may photocopy and use as many as you need.

Date

Completed by Prabhakar R. Thangudu

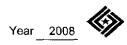
Title <u>HSE Manager</u>
Phone <u>713-676-1460</u>

| , , | | |
|---|-----|---|
| 1) Full Name David Vandenberg | 10) | Case number from the Log6 (Transfer the case number from the Log after you record the case.) |
| 2) Street (b) (4) | 11) | Date of injury or illness <u>11/3/2008</u> |
| City (b) (4) State (b) Zip (b) | 12) | Time employee began work 6:00 AM AM/PM |
| 3) Date of birth | 13 | Time of event 5 PM AM/PM Check if time cannot be determined |
| 4) Date hired (b) (4) 5) X Male Female | 14) | What was the employee doing just before the incident occurred? Describe the activity, as well as the tools, equipment or material the employee was using. Be specific. Examples: "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key-entry." |
| | | On the truck ladder |
| Information about the physician or other health care professional | | |
| 6) Name of physician or other health care professional | 15) | What happened? Tell us how the injury occurred. Examples: "When ladder slipped on wet floor, work fell 20 feet"; "Worker was spayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time." |
| St. Elizabeth Hospital | | Fell off the ladder |
| 7) If treatment was given away from the worksite, where was it given? | | |
| Facility St. Elizabeth Hospital | 16) | What was the injury or illness? Tell us the part of the body that was affected and now it was affected |
| Street 2830 Calder St | | be more specific than "hurt", "pain", or "sore." Examples: "strained back"; "chemicel burn, hand"; "carp tunnel syndrome." Head and spinal injury |
| City Beaumont State TX Zip 77702 | | Tread and spirital rijory |
| 8) Was employee treated in an emergency room? | | |
| X Yes No | 17) | What object or substance directly harmed the employee? Examples: "concrete floor"; "chlorine"; "radial arm saw." If this question does not apply to the incident, leave it blank. Concrete floor |
| 9) Was employee hospitalized overnight as an in-patient? | | |
| Yes | | |
| □ No | 18\ | If the employee died, when did death occur? Date of death |

Public reporting burden for this collection of information is estimated to average 22 minutes per response, including time for reviewing instructions, searching existing data sources, gethering and maintaining the data needed, and completing and reviewing the collection of information. Persons are not required to respond to the collection of information unless it displays a current valid OMB conflot number. If you have any comments about this estimate or any other aspects of this data collection, including suggestions for reducing this burden, contact: US Department of Labor, OSHA Office of Statistics, Room N-8444, 200 Constitution Ave, NW, Washington, DC 20210. O not send the completed from to this office.

PAHO042001603

OSHA's Form 300A Summary of Work-Related Injuries and Illnesses



U.S. Department of Labor

Occupational Safety and Health Administration

Form approved OMB no. 1218-0176

All establishments covered by Part 1904 must complete this Summary page, even if no injuries or illnesses occurred during the year. Remember to review the Log to verify that the entries are complete

Using the Log, count the individual entries you made for each category. Then write the totals below, making sure you've added the entries from every page of the log. If you had no cases write "0."

Employees former employees, and their representatives have the right to review the OSHA Form 300 in its entirety. They also have limited access to the OSHA Form 301 or its equivalent. See 29 CFR 1904.35, in OSHA's Record

| Number of Cases | | | |
|--|--|---|--|
| Total number of deaths | Total number of cases with days away from work | Total number of cases with job transfer or restriction | Total number of other recordable cases |
| 0 (G) | 4 (H) | 0 (1) | (J) |
| Number of Days | | | |
| Total number of days of job transfer | | Total number of days away from work | |
| or restriction 76 (K) | | 89 (L) | |
| injury and illness T | ypes ? | | |
| Total number of (M) | | | |
| (1) Injury (2) Skin Disorder (3) Respiratory | 11 | (4) Poisoning(5) All other illnesses | 0 |
| Condition | 0 | | |

Post this Summary page from February 1 to April 30 of the year following the year covered by the form

Public reporting burden for this collection of information is estimated to average 50 minutes per response, including time to review the instruction, search and gather the data needed, and complete and review the collection of information. Persons are not required to respond to the collection of information unless it displays a currently valid OMB control number. If you have any comments about these estimates or any aspects of this data collection, contact. US Department of Labor. OSHA Office of Statistics, Room N-3644, 200 Constitution Ave. NW. Washington, DC 20210. Do not send the completed forms to this office.

| Your establishment name <u>CES Environmental Services Inc.</u> | |
|--|-------------------------------|
| Street 4904 Griggs Road | |
| City Houston State | TX Zip77021 |
| Industry description (e.g., Manufacture of motor truck traiters) Environmental services, tank cleaning, trucking | |
| Standard Industrial Classification (SIC), if known (e.g., SIC 3719 | 5) |
| Employment information | |
| Annual average number of employees128 | |
| Total hours worked by all employees lest year 389,233 | |
| Sign here | |
| Knowingly falsifying this document may result in a fine. | |
| I certify that I have examined this document and that to the best are true, accurate, and complete. | t of my knowledge the entries |
| Trooth | Manager |
| Company executive | Title |
| 713-676-1460 | 1/2/2009 |
| Phone | |

OSHA's Form 300 Log of Work-Related Injuries and Illnesses

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

| Year | 2008 | |
|---------------|----------------|------------------|
| U.S. De | partmen | t of Labor |
| Joational Sal | fety and Healt | h Administration |

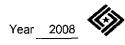
You must record information about every work-related injury or liness that involves loss of consciousness, restricted work activity or job transfer, days away from work, or medical treatment beyond first aid. You must also record significant work-related injuries and illnesses that are diagnosed by a physician or licensed health care professional. You must also record work-related injuries and illnesses that meet any of the specific recording criteria listed in 29 CFR 1904.8 through 1904.12. Feel free to use two lines for a single case if you need to. You must complete an injury and illness incident report (OSHA Form

Form approved OMB no. 1218-0176

|)1) or e | quivalent form for each injury or iline: | s recorded on this fo | rm. If you're n | ot sure whether a case is recordable, call | your local OSHA office for help. | | | Establishin | ent name | CEO EIIV | ronmeniai | Services | i, INC. | | | |
|--------------------|--|--|--------------------------------|--|---|----------|-----------------|---|----------------|--|-----------------------------|------------------------|--|-----------------------------|-----------|--------------------|
| | | | | | | | | City | Houston | | | State | Texa | s | | |
| ering King | Identify the person | | 4.04 | Describe | the case | Class | ify the case | io praj j | | 1 | | | | P-14-4 | | |
| (A) Case No. | (B) Employee's Name | (C) Job Title (e.g., Welder) | (D) Date of injury or onset of | (E) Where the event occurred (e.g. Loading dock north end) | (F) Describe injury or illness, parts of body affected, and object/substance that directly injured or made person ill (i.e.g. Second degree burns on right forearm from acetylend | serious | result for each | es, check ONL' h case: whiteness stadis | | the injured o | | Check the lype of ille | ness: | ∕ colume a essera | | se one |
| i | · | | illness (mo./day) | , | torch) | 40. 4. 6 | trom work | Job transfer | | On job transfer or restriction (days) | Away from work (days) | lnjury | Skin Disorder | Respiratory Condition | Poisoning | All other illnesse |
| | 1 | | | | | (G) | (H) | (I) | (J) | (K) | (L) | (1) | (2) | (3) | (4) | (5) |
| 1 | Joaquinn Ramerez Alvarez | Tankwash Tech | 1/24 | Tank Wash Bay 1 | Pain in hip, wrist, and hand from fall | | × | | | 67 | 1 | × | | 1 1 | 1 | |
| | Sebastian McCrimmons | Driver . | 5/6 | Unloading Dock | Burns | | <u> </u> | | | 9 | 1 | | × | | | |
| 3 | Farrier Riley | Driver | 5/22 | Entering premises | Cuts | | × | | ì | | 29 | х | | | | |
| 4 | Darryi Johnson | Warehouse Tec | 8/6 | South end of unloading dock | Heat stress | | × | | | | 1 | | \Box | | | |
| 5 | Scott Shimer | Manager | 10/22 | Maintenance Shop | Cut | T | T | | | | | × | | | | |
| 6 | David Vandenberg | Driver | 11/3/08 | Newpark Env., Winnie, TX | Fracture | | × | | | | 58 | х | | | | |
| | | | | | | - | - | | | | - | | | $\vdash \vdash \vdash$ | ├──┤ | ~ |
| | | | | | | ╁ | | <u></u> | | | | - | | | \vdash | |
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| | | <u> </u> | <u> </u> | | Page totals | 0 | 4 | 0 | 0 | 76 | 89 | | +- | 0 | 0 | 0 |
| | | | | | * | | · | | | <u> </u> | | | المستسلم | <u>`</u> | I | |
| Public n | eporting burden for this collection of i | nformation is estimate | ed to average 1 | 14 minutes per response, including time to | Be sure to transfer these totals to | the Si | ummary pag | ge (Form 30 | IOA) before yo | ou post it. | | Injury | Disorder | spiratory Condition | olsoníng | linesses |

review the instruction, search and gather the data needed, and complete and review the collection of information. Persons are not required to respond to the collection of information unless it displays a currently valid OMB control number. If you have any comments about these estimates or any aspects of this data collection, contact: US Department of Labor, OSHA Office of Statistics, Room N-3644, 200 Constitution Ave, NW, Washington, DC 20210. Do not send the completed forms to

OSHA's Form 300A Summary of Work-Related Injuries and Illnesses



U.S. Department of Labor

Form approved OMB no. 1218-0176

Occupational Safety and Health Administration

All establishments covered by Part 1904 must complete this Summary page, even if no injuries or illnesses occurred during the year. Remember to review the Log to verify that the entries are complete

Using the Log, count the individual entries you made for each category. Then write the totals below, making sure you've added the entries from every page of the log. If you had no cases write "O."

Employees former employees, and their representatives have the right to review the OSHA Form 300 in its entirety. They also have limited access to the OSHA Form 301 or its equivalent. See 29 CFR 1904.35, in OSHA's Record

| Total number of deaths | Total number of cases with days away from work | Total number of cases with job transfer or restriction | Total number of other recordable cases |
|--------------------------------------|--|--|--|
| · 0 (G) | 3 (H) | 1 (1) | 0 |
| Number of Days | | | |
| Total number of days of job transfer | | Total number of days away from work | |
| or restriction 76 (K) | | 31 (L) | <u>-</u> |
| Injury and Illness T | ypes | | |
| Total number of (M) | | | |
| (1) Injury | 2 | (4) Poisoning | 0 |
| (2) Skin Disorder | 1 | (5) All other illnesses | 0 |

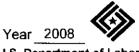
Post this Summary page from February 1 to April 30 of the year following the year covered by the form

Public reporting burden for this collection of information is estimated to average 50 minutes per response, including time to review the instruction, search and gather the data needed, and complete and review the collection of information. Persons are not required to respond to the collection of information unless it displays a currently valid OMB control number. If you have any comments about these estimates or any aspects of this data collection, contact: US Department of Labor. OSHA Office of Statistics. Room N-3644. 200 Constitution Ave. NW. Washinaton, DC 20210. Do not send the completed forms to this office.

| Estal | blishment inforn | nation | | | | |
|---------|---|---|----------------|-------------|------------|------------|
| Your e | stablishment name | CES Environmenta | l Services Inc | | | |
| Street | 4904 Griggs Road | | | , | | |
| City | Houston | | State _ | TX | Zip _ | 77021 |
| indust | | Manufacture of motor vices, tank cleaning, to | | | | |
| Stand | ard Industrial Classif | ication (SIC), if known | (e.g., SIC 37 | 15) | | |
| | | | . • | ŕ | | |
| | | | | | | |
| Emp | loyment informa | ition | | | | |
| | | | | | | |
| Annua | al average number of | employees | 126 | | | |
| Total I | hours worked by all e | employees last year | 277,316 | | | |
| | | | | | | |
| Sian | here | | | | | |
| • | | | F | | | |
| Know | ingly talsitying this do | ocument may result in | a fine. | | | |
| | | | | | - | |
| | fy that I have examin ue, accurate, and co | ed this document and mplete. | that to the be | est of my k | nowiedge t | he entries |
| | | | | | | ager |
| | Comp | any executive | | | Ti | tle |
| | 71: | 3-676-1460 | | | | 2008 |
| | | Phone | | | Da | ate |

OSHA's Form 300 Log of Work-Related Injuries and Illnesses

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.



U.S. Department of Labor

Occupational Safety and Health Administration

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TRIBLE - ASMINIST UNIVERSE UNIVERSE OF THE PROPERTY OF THE PRO You must record information about every work-related injury or illness that involves loss of consciousness, restricted work activity or job transfer, days away from work, or medical treatment beyond first aid. You must also record significant work-related injuries and illnesses that are diagnosed by a physician or licensed health care professional. You must also record work-related injuries and illnesses that meet any of the specific recording criteria listed in 29 CFR 1904.8 through 1904.12. Feel free to use two lines for a single case if you need to. You must complete an injury and illness incident report (OSHA Form 301) or equivalent form for each injury or illness recorded on this form. If you're not sure whether a case is recordable, call your local OSHA office for help.

Establishment name CES Environmental Services, Inc. Houston State Texas

| W1.25 | Identify the person | | | Describe | the case | Class | ify the case | | | | | Way. | CHAPTANE. | /\ | 10000 | - 15 OH |
|--------------------|--------------------------|------------------------------------|--------------------------------|--|---|----------|----------------|--------------------------------|--------------------------------------|--|-----------------------------|-----------|---------------|--------------------------|-------------|--------------------|
| (A) Case No. | (8) Employee's Name | (C) Job Title (e.g., Welder) | (D) Date of injury or onset of | (E) Where the event occurred (e.g. Loading dock north end) | (F) Describe injury or illness, parts of body affected, and object/substance that directly injured or made person ill (e.g. Second degree burns on right forearm from acetylene | serious | result for eac | es, check ONL' th case: | Y the most | the injured o | | Check the | ness: | r" columr | | |
| | | | illness (mo./day) | | (erg Second degree puris or right lorealith from acceptant | Death | HOTH WOR | Job transfer or restriction | ed at work Other record- able cases | On job transfer or restriction (days) | Away from work (days) | Injury | Skin Disorder | Respiratory Condition | : Poisoning | All other illnesse |
| | | | | | | (G) | (H) | (1) | (J) | (K) | (L) | (1) | (2) | (3) | (4) | (5) |
| 1 | Joaquinn Kamerez Aivarez | Tankwash Tech | 1/24 | Tank Wash Bay 1 | Pain in hip, wrist, and hand from fall | | х | x | | 67 | 1 | x | | | | |
| 2 | Sebastian McCrimmons | Criver | 5/6 | Unloading Dock | Bums | | | | | 9 | | | × | | | |
| 3 | Farrier Riley | Driver | 5/22 | Entering premises | Cuts | <u> </u> | × | | | L | 29 | х | L | | | |
| 4 | Darryl Johnson | V/arehouse Ted | 8/6 | South end of unloading dock | Heat stress | | X | | | | 1 | | | | | |
| | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| | | · | | | Page totals | 0 | 3 | 1 | 0 | 76 | 31 | 2 | 1 | 0 | 0 | 0 |

Be sure to transfer these totals to the Summary page (Form 300A) before you post it.

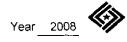
1 of 1

(3)

Public reporting burden for this collection of information is estimated to average 14 minutes per response, including time to review the instruction, search and gather the data needed, and complete and review the collection of information. Persons are not required to respond to the collection of information unless it displays a currently valid OMB control number. If you have any comments about these estimates or any aspects of this data collection, contact. US Department of Labor, OSHA Office of Statistics, Room N-3644, 200 Constitution Ave. NW, Washington, DC 20210. Do not send the completed forms to

PAHO042001607

OSHA's Form 300A Summary of Work-Related Injuries and Illnesses



U.S. Department of Labor

Form approved OMB no. 1218-0176

Occupational Safety and Health Administration

All establishments covered by Part 1904 must complete this Summary page, even if no injuries or illnesses occurred during the year. Remember to review the Log to verify that the entries are complete

Using the Log, count the individual entries you made for each category. Then write the totals below, making sure you've added the entries from every page of the log. If you had no cases write "0."

Employees former employees, and their representatives have the right to review the OSHA Form 300 in its entirety. They also have limited access to the OSHA Form 301 or its equivalent. See 29 CFR 1904.35, in OSHA's Recordkeeping rule, for further details on the access provisions for these forms.

Number of Cases Total number of Total number of Total number of cases Total number of cases with days deaths with job transfer or other recordable away from work restriction cases Number of Days Total number of Total number of days days of job transfer away from work or restriction injury and litness Types Total number of... (M)(1) Injury (4) Poisoning (2) Skin Disorder (5) All other iflnesses (3) Respiratory Condition

Post this Summary page from February 1 to April 30 of the year following the year covered by the form

Public reporting burden for this collection of information is estimated to average 50 minutes per response, including time to review the instruction, search and gather the date needed, end complete and review the collection of information. Persons are not required to respond to the collection of information unless it displays a currently valid OMB control number. If you have any comments about these estimates or any aspects of this data collection, contact. US Department of Labor, OSHA Office of Statistics, Room N-3644, 200 Constitution Ave. NW. Washington, DC 20210. Do not send the completed forms to this office.

| Your e | stablishment name | CES Environmental | Services Inc | c. | | |
|----------|-------------------------|--------------------------|----------------|-------------|---------------|-------------|
| Street | 4904 Griggs Road | | | <u></u> | | |
| City | Houston | | State | TX | Zip | 77021 |
| Jny | Houston | | 31818 | | _ Zip _ | 17021 |
| indust | | lanufacture of motor to | | | | |
| | Environmental serv | ices, tank cleaning, tri | ucking | | . | |
| Standa | ard Industrial Classifi | cation (SIC), if known | (e.g., SIC 37 | 15) | | |
| , | 1 5 | | | / | | |
| | | | | | | |
| | | | | | | |
| Empl | oyment informa | tion | | | | |
| | | | | | | |
| | | | | | | |
| Annua | l average number of | employees | 132 | | | |
| T-1-1 1 | anna marka dibir alli a | | 210.005 | | | |
| I OTAL I | ours worked by all e | mpioyees last year | 316,865 | | | |
| | | | | | | |
| ٥ | | | | | | |
| Sign | nere | | | | | |
| Knowi | ngiv falsifying this do | cument may result in a | a fine. | | | |
| | . g., | | | | | |
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| | | | | | | |
| | | ed this document and | that to the be | est of my l | knowledge | the entries |
| are tru | e, accurate, and cor | nplete. | | | | |
| | | | | | B4 a | nager |
| | Comp | any executive | | | | itle |
| | · | - | | | | |
| | | | | | | |
| | 713 | 1-676-1460 | | | 1/2 | /2008 |

CONFINED SPACE ENTRY PERMIT

(TO BE COMPLETED BY THE ENTRY SUPERVISOR)

SECTION A: GENERAL INFORMATION (PLEASE PRINT)

| 1. Description of the Confined Space: Tank Gutay |
|--|
| 2. Description of Work to be Performed: MEMOUT WATER + SOLIDS |
| 3. Date Issued: 7/2/09 4. Time Issued: 9:30 pm |
| 5. Date Expires: 7 /2 /09 6. Time Expires: 5:00 am form |
| 7. Attendant: Woodso 8.Entry Supervisor: Herwy DEE |
| SECTION B: CHECKLIST FOR ISOLATION AND UNAUTHORIZED ACCESS PREVENTION (Circle the correct answer for each question). |
| 1. Are external barriers in place? YES NO NA |
| |
| 2. Has mechanical lockout/tagout been completed? NO N/A |
| 3. Has electrical lockout/tagout been completed? |
| 4. Have other De-energizing steps been completed? YES NO W |
| 5. Have lines/pipes been disconnected? YES NO DES |
| 6. Have lines/pipes been blocked? YES NO WA |
| 7. Have lines/pipes been capped? YES NO WA |
| 8. Have barricades been set up? YES NO A |
| 9. Have warning signs been placed? YES NO NA |
| 10. Any possible overhead falling debris YES N/A |
| Report Unauthorized Entry to: S. STAICKER |
| Phone: 281-433-7652 |
| SECTION C: PRE-ENTRY CHECKLIST (Check or fill in the correct answers). |
| 1. Purging: Were lines/pipes purged? [] YES [] NO [YN/A |
| If so, what method was used? [Nitrogen [] Steam [] Water [] Other (Specify): |
| 2. VENTILATION: Is forced ventilation being maintained? YES [] NO [] N/A |
| 3. ATMOSPHERIC GAS TESTS PERFORMED BY: Woodard |

| TESTER INFORMATION | ATMOSPHERIC HAZARD TESTED | ACCEPTABLE RANGE OF HAZARD | ACTUAL READING (Record) | ACCEPTABLE? (Circle One) |
|-----------------------|---------------------------------|----------------------------------|-------------------------------|-----------------------------|
| DATE: 7 / 2 / 09 | Oxygen Content (% O2) | 19.5% - 23.5% | 20.9 % | VES NO |
| TIME: 7.30 | Combustible Gas (% LEL) | 0% - 10% | & % | YES NO |
| SIGNATURE: | Other:(Specify): | PEL = ppm | > ppm | NO NO |

CAUTION: Toxic or flammable gases or vapors may stratify in the confined space. Be sure to test at various levels and locations within the confined space. Always check the oxygen content first.

| [] P: [] Sc | ainting or Solvent-Cleaning M Cleaning/Sween craping/Removing Residue MOTHER | ping/Vacuuming |
|----------------------|---|-----------------|
| (expl | ain): REMOVING HEEL & M | ressure washing |
| 5. RI | ESCUE PROCEDURE: | |
| | CALL 911 | |
| RES Nan | SCUE PERSONNEL: nes: Phone: S. STRICKER 29/-433-7052 CES 2/3-676-1460 | |
| 6. SP | ECIAL EQUIPMENT NEEDED (Check): | |
| [] [] [] [] | Air-Purifying Respirators Air-Supplying Respirators Air-Supplying Respirators with Escape Bottle SCBA or Supplied Air (for rescue personnel) Safety Harnesses | |
| 1 | Lifelines Hoisting Apparatus Communications Equipment: W/SV4L Temporary Lighting Non-Sparking Tools | + vensa l |

CONFINED SPACE PERSONNEL ENTRY LOG (PLEASE PRINT)

| Space: Z- | MENT | zey (69. | ATEN T | ruk) | |
|------------|--------------------|-----------------------|--|---|--|
| | | _ | | | |
| Soto, | RAMIR | æ | | | |
| TIME IN | TIME OUT | TIME IN | TIME OUT | TIME IN | TIME OUT |
| 9:40 | 11:20 | | | | |
| 9,-40 | 1520 | | | | |
| | | | | | |
| | | | | | |
| 9:40 | 10:20 | | | | |
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| | | | <u> </u> | | |
| | | | | | |
| | | | | <u> </u> | |
| | | | | | |
| | | | | | |
| | Soto, TIME IN 9:40 | SOTO RAMINE TIME TIME | Date: Soto Raminace TIME TIME TIME IN OUT IN 9:40 /1:20 9:40 /1:20 | Soto Ramines TIME TIME TIME TIME OUT 9:40 /1:20 9:40 /1:20 | TIME TIME TIME TIME IN Q: Yo /1:20 9:40 / 1:20 |

PERIODIC ATMOSPHERIC GAS TEST RESULTS

Description of the Confined Space: TANK ENTRY (WATER TANK)

| TESTER | ATMOSPHERIC | ACCEPTABLE | ACTUAL | ACCEPTABLE? (Check |
|------------------|----------------------------|--------------------|---------------------|--------------------|
| INFORMATION | HAZARD TESTED | RANGE OF HAZARD | READING (RECORD) | One) YES NO |
| Date: | Oxygen Content | UNDARD | (RECORD) | YES NO |
| 7/2/09 | (% O2) | 19.5%-23.5% | 20.9% | NO NO |
| Time: 9-30 | Combustible Gas (% LEL) | 0%-10% | 8 % | NO NO |
| Signature: | Other (Specify): | PEL = ppm | ₩ ^{ppm} | YES NO |
| · , | | | | |
| Date: / / | Oxygen Content (% O2) | 19.5%-23.5% | % | YES NO |
| Time: | Combustible Gas (% LEL) | 0%-10% | % | YES NO |
| Signature: | Other (Specify): | PEL = ppm | ppm | YES NO |
| | | | | |
| Date: / / | Oxygen Content (% O2) | 19.5%-23.5% | % | YES NO |
| Time: | Combustible Gas (% LEL) | 0%-10% | % | YES NO |
| Signature: | Other (Specify): | PEL = ppm | ppm | YES NO |
| | | | | |
| Date: | Oxygen Content (% O2) | 19.5%-23.5% | % | YES NO |
| Time: | Combustible Gas (% LEL) | 0%-10% | % | YES NO |
| Signature: | Other (Specify): | PEL = ppm | ppm | YES NO |
| Date: | Oxygen Content | | | YES NO |
| / / | (% O2) | 19.5%-23.5% | % | ILS NU |
| Time: | Combustible Gas (% LEL) | 0%-10% | % | YES NO |
| Signature: | Other (Specify): | PEL = ppm | ppm | YES NO |

NOTE: RETAIN WITH THE CONFINED SPACE ENTRY PERMIT FOR A MINIMUM OF 5 YEARS.

RECORD MONITORING RESULTS AT LEAST EVERY TWO HOURS.

RETURN PERMIT TO SAFETY AT COMPLETION OF JOB.

customee + LW Miller.

(HANKWASH)

CONFINED SPACE ENTRY PERMIT

(TO BE COMPLETED BY THE ENTRY SUPERVISOR)

SECTION A: GENERAL INFORMATION (PLEASE PRINT)

| 1. Description and Location of the Confined Space: 15 A, 4 | |
|--|-------------------------------|
| 2. Description of Work to be Performed: | |
| 3. Date Issued: 7/94/09 4. Time Issued: 5. Date Expires: 7/94/09 6. Time Expire | |
| 5. Date Expires: 7 / 34 / 0 6. Time Expire 7. Attendant: \(\frac{2}{3} \text{upper} \) \(\frac{1}{2} \text{Upper} \) \(| |
| SECTION B: CHECKLIST FOR ISOLATION AND PREVENTION (Circle the correct answer for each question). | O UNAUTHORIZED ACCESS |
| 1. Are external barriers in place? | YES NO N/A |
| 2. Has mechanical lockout/tagout been completed? | YES NO N/A |
| 3. Has electrical lockout/tagout been completed? | YES NO N/A |
| 4. Have other De-energizing steps been completed? If so, describe: | YES NO N/A |
| 5. Have lines/pipes been disconnected? | YES NO NA |
| 6. Have lines/pipes been blocked? | YES NO N/A |
| 7. Have lines/pipes been capped? | YES NO N/A |
| 8. Have barricades been set up? | YES NO N/A |
| 9. Have warning signs been placed? | YES NO N/A |
| 10. Any possible overhead falling debris | YES NO N/A |
| Report Unauthorized Entry to: | , |
| SECTION C: PRE-ENTRY CHECKLIST (Check or | fill in the correct answers). |
| 1. Purging: Were lines/pipes purged? | YES [] NO [4N/A |
| If so, what method was used? [Nitrogen Ste Other (Specify): | • • |
| 2. VENTILATION: Is forced ventilation being maint: | ained? [YES] [NØ [])N/A |
| 3. ATMOSPHERIC GAS TESTS PERFORMED | BY: ams |
| | |

CONFINED SPACE ENTRY PERMIT □ Stand Alone <u>vaild</u> for one shift □ Parallei Verification Date and Time Expires: 4 Date and Time Issued: Jobsite/Space ID: _ ケイ Job Supervisor: + Equipment to be worked on: Work to be performed: Standby Personnel: 3.44 MSDS□ YES □ NO Chemical(s) Involved: Hazards □ Flammable □ Corrosive □ Reactive □ Toxic □ Temperature >100 or <50 □ Engulfment 1. Atmospheric Checks: Time: // 30 Explosive Continuous Monitoring Instrument Calibration Date ______ Tester's Signature 2. Source Isolation: Pump or lines blinded?

Yes

No Disconnected or blocked? ☐ Yes ☐ No Note: All LOTO procedures must be followed. 3. Ventilation Modification: Mechanical Fan or Blower? Z Yes D No Natural Ventilation Only D Yes D No 4. Atmospheric check after isolation and ventilation: Time 10. Explosive/ Tester's Signature: 5. Communication procedures: □ Radio © Rope □ Sound □ Tactile 6. Rescue Procedures: CAL 7. Successfully completed Confined Space Entry required training? □ No Is it current? □ No 8. Equipment: Gas monitor tested? □ No □ N/A Safety harnesses and lifelines for entry and Standby persons? □ No □ N/A Davit or Tripod equipment? □ N/A Powered communications? ⊡No □ N/A SCBA(s) for entry & standby persons? □ No □ N/A Protective clothing? □ No $\square N/A$ All electric equipment listed Class 1, Division I, Group D and Non-Sparking? □ N/A □ Yes □ No Note: GFCI must be in place for Electrical hand tools. 9. Periodie atmospheric tests: (Additional space provided on next page) Time Toxic % % We have reviewed the work authorized by this permit and the information contained herein. Written instructions and safety procedures have been received and are understood. Entry cannot be approved if any squares are

marked in the "No" column. This permit is not valid unless all appropriate items are completed.

finted Name)

(Printed Name)

(Printed Name)

Permit Prepared By: (Supervisor)

Approved By

Reviewed By

EDALLO0400040

(Signature)

(Signature)

OSHA site visit 12-17-08 Records submitted

OSHA's Form 300A Summary of Work-Related Injuries and Illnesses



U.S. Department of Labor

Occupational Safety and Health Administration

All establishments covered by Part 1904 must complete this Summary page, even if no injuries or illnesses occurred during the year. Remember to review the Log to verify that the entries are complete

Using the Log, count the individual entries you made for each category. Then write the totals below, making sure you've added the entries from every page of the log. If you had no cases write "0."

Employees former employees, and their representatives have the right to review the OSHA Form 300 in its entirety. They also have limited access to the OSHA Form 301 or its equivalent. See 29 CFR 1904.35, in OSHA's Recordkeeping rule, for further details on the access provisions for these forms.

| Number of Cases | | | |
|--|--|--|--|
| Total number of deaths | Total number of cases with days away from work | Total number of cases with job transfer or restriction | Total number of other recordable cases |
| 0 | 1 | 1 | _ 1 |
| (G) | (H) | (1) | (J) |
| Number of Days | | | |
| Total number of days of job transfer | | Total number of days away from work | |
| or restriction 261 (K) | - | 18 (L) | _ |
| injury and illness I | ypes (fight) | | |
| Total number of (M) | | | |
| (1) Injury (2) Skin Disorder (3) Respiratory | 0 | (4) Poisoning (5) All other illnesses | 0 0 |
| Condition | 0 | | |

Post this Summary page from February 1 to April 30 of the year following the year covered by the form

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| Your establishment name CES Env | vironmentat Services Inc. |
|---|--|
| Street 4904 Griggs Road | |
| City Houston | State TX Zip 77021 |
| Industry description (e.g., Manufacture Environmental services, tank c | • |
| Standard Industrial Classification (SIC) |), if known (e.g., SIC 3715) |
| Employment information | |
| Employment unormation | |
| | |
| Annual average number of employees | |
| Total hours worked by all employees la | ast year <u>206,868</u> |
| | |
| Sign here | |
| Manufack Salais in this down at me | y result in a fine. |
| Knowingly falsifying this document may | |
| Knowingly raisitying tris document ma | |
| Anowingly laisifying dus document ma | |
| I certify that I have examined this docu | ument and that to the best of my knowledge the entries |
| I certify that I have examined this docu are true, accurate, and complete. | Manager |
| | Manager |
| I certify that I have examined this docu are true, accurate, and complete. | ive Title |

OSHA's Form 300 Log of Work-Related Injuries and Illnesses

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

Year 2006

U.S. Department of Labor

Occupational Safety and Health Administration

Form approved OMB no. 1218-0176

You must record information about every work related injury or illness that involves loss of consciousness, restricted work activity or job transfer, days away from work, or medical treatment beyond first aid. You must also record significant work-related injuries and illnesses that are diagnosed by a physician or licensed health care professional. You must also record work-related injuries and illnesses that meet amy of the specific recording orderia listed in 29 CFR 1904.8 through 1904.12. Feel free to use two lines for a single case if you need to. You must complete an injury and illness incident report (OSHA Form 301) or equivalent form for each injury or illness recorded on this form. If you're not sure whether a case is recordable, call your local OSHA office for help.

CES Environmental Services, Inc. Establishment name Houston State Texas Classify the case ministration of the second Identify the person. Enter the number of days _ (A) the injured or ill worker Using these categories, check ONLY the most Check the "injury" column or choose one Job Title (e.g. Where the event occurred (e.g. Case Employee's Name Date of Describe injury or illness, parts of body affected, and serious result for each case: type of illness: was: No. Weider injury or Loading dock north end) object/substance that directly injured or made person iff EL SANGARUS - ARROPOTOTOS - APPRARA onset of (e.g. Second degree burns on right forearm from acetylene On job iliness Days away Death Remained at work transfer or work (mo./day) from work restriction (days) lob transfer Other record-(days) or restriction able cases (3) (G) (H)Robert B. Henry Hurt lower back from lifting a drum lelper 7/17/2006 [Drum disposal facility Glen Olson Machanic 8/23/2006 CES Yard Left ankle injured that was caught under trailer tire 246 18 x 0 Glen Olson dechanic 12/15/2006 Road Side off of Clinton Dr., I-810 Sore left knee when slipped off truck tire Page totals 3 18 Be sure to transfer these totals to the Summary page (Form 300A) before you post it. Public reporting burden for this collection of information is estimated to average 14 minutes per response, including time to

review the instruction, search and gather the data needed, and complete and review the collection of information. Persons are not required to respond to the collection of information unless it displays a currently yalid OMB control number. If you have any comments about these estimates or any aspects of this data collection, contact: US Department of Labor, OSHA Office of Statistics, Room N-3644, 200 Constitution Ave, NW, Washington, DC 20210. Do not send the completed forms to

1 of 1

(3)

PAHO042001618

OSHA's Form 300A Summary of Work-Related Injuries and Illnesses



U.S. Department of Labor

Occupational Safety and Health Administration

All establishments covered by Part 1904 must complete this Summary page, even if no injuries or illnesses occurred during the year. Remember to review the Log to verify that the entries are complete

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Employees former employees, and their representatives have the right to review the OSHA Form 300 in its entirety. They also have limited access to the OSHA Form 301 or its equivalent. See 29 CFR 1904.35, in OSHA's Recordkeeping rule, for further details on the access provisions for these forms.

| Number of Cases | | | |
|--------------------------------------|--|---|--|
| Total number of deaths | Total number of cases with days away from work | Total number of cases with job transfer or restriction | Total number of other recordable cases |
| 0 | cases with days away from work 0 0 1 (G) (H) (I) umber of Days otal number of ays of job transfer or restriction 10 0 (K) 0 ijury and illness types otal number of (M) I) Injury 1 (4) Poisoning (5) All other illnesses | 1 | 0 |
| (G) | (H) | (l) | (J) |
| Number of Days | len ilizza je u je u je u je u je u je u je u je | 月月17年 1980年 | |
| Total number of days of job transfer | | _ | |
| 10 | - | | _ |
| | | 147 (157) 14 (157) 15 (157) 16 (157) | |
| Total number of (M) | | | |
| (1) Injury | 1 | (4) Poisoning | 0 |
| ` ' | 0 | (5) All other illnesses | 0 |
| | | | |
| Condition | n | | |

Post this Summary page from February 1 to April 30 of the year following the year covered by the form

Public reporting burden for this collection of information is estimated to average 50 minutes per response, including time to review the instruction, search and gather the data needed, and complete and review the collection of information. Persons are not required to respond to the collection of information unless it displays a currently valid OMB control number. If you have any comments about these estimates or any expects of this data collection, contact. US Department of Labor, OSHA Office of Statistics, Room N-3644, 200 Constitution Ave. NW. Washinston, DC 20210. Do not send the completed forms to this office.

| Establishment in | nformation | | | | |
|---|-----------------------|-----------------------|-------------|-------------|---------------------------------------|
| Your establishment r | ame CES Enviro | nmental Services In | ıc. | | · · · · · · · · · · · · · · · · · · · |
| Your establishment information Your establishment name CES Environmental Services Inc. Street 4904 Griggs Road City Houston State TX Zip 77021 Industry description (e.g., Manufacture of mofor truck trailers) Environmental services, tank cleaning, trucking Standard Industrial Classification (SIC), if known (e.g., SIC 3715) 1 5 4 2 Employment information Annual average number of employees 98 Total hours worked by all employees last year 297,255 Sign here Knowingly falsifying this document may result in a fine. | | | | | |
| City <u>Houston</u> | | State | тх | _ Zip _ | 77021 |
| | | | ı | | |
| | | f known (e.g., SIC 3 | 715) | | |
| 15 | 4 _2 | | | | |
| Employment inf | ormation | | | | |
| | | | | | |
| | | | | | |
| Annual average num | ber of employees | 98 | - | | |
| Fotal hours worked t | ıy all employees last | year <u>297,255</u> | - | | |
| | | | | | |
| Sign here | | | | | |
| Knowingly falsifying | this document may r | esult in a fine. | | | |
| , | | | | | |
| | | | | | |
| | | ent and that to the b | est of my l | rnowledge t | the entries |
| | | | _ | | nager |
| | Company executive | | | Ti | itle |
| | 713-676-1460 | | _ | 1/2/ | 2008 |
| | Phone | | | Da | ate |

OSHA's Form 300 Log of Work-Related Injuries and Illnesses

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

| Year | 2007 | >// |
|------|------|---------------|
| | • | t of Labor |

U.S. Department of Labor
Occupational Safety and Health Administration

State Texas

Form approved OMB no. 1218-0176

| You must record information about every work-related injury or illness that involves loss of consciousness, restricted work activity or job transfer, days away from work, or medical treatment beyond first aid. | | Form approv |
|---|-------------------|----------------------------------|
| You must also record significant work-related injuries and illnesses that are diagnosed by a physician or licensed health care professional. You must also record work-related injuries and illnesses that meet | | |
| erry of the specific recording criteria listed in 29 CFR 1904.8 through 1904.12. Feel free to use two lines for a single case if you need to. You must complete an injury and illness incident report (OSHA Form | stablishment name | CES Environmental Services, Inc. |
| 301) or equivelent form for each injury or illness recorded on this form. If you're not sure whether a case is recordable, call your local OSHA office for help. | • | |

| (A) Case No. | (B) Employee's Name | (C) Job Title (e.g., Welder) | (D) Date of injury or onset of illness (mo./day) | (E) Where the event occurred (e.g. Loading dock north end) | (F) Describe injury or illness, parts of body affected, and object/substance that directly injured or made person ill (e.g. Second degree burns on right forearm from acetylene torch) | serious Death | result for eac | Remain Job transfer | Y the most | the injured o | | Check the | ness: | Respiratory Condition | | |
|--------------------|------------------------|------------------------------------|--|--|--|------------------|----------------|------------------------|------------|---------------|-----|-----------|----------|-----------------------|---------------|------------|
| | | | | | | (G) | (H) | (1) | (J) | (K) | (L) | .⊆ (1) | の (2) | _ @ O (3) | .cī. (4) | न्द (5) |
| 1 | Percy Foster | Technician | 9/13/2007 | 17225 El Camino Rd | Cut finger | | | х | | 10 | | х | | | | |
| | | | | | | ├ | | | | <u> </u> | 1 | | | | | |
| | | | | | | | | | | | | | | | | |
| | | + | | | | 1 | | 1 | | | | | | | - | |
| | | - | | | | | | | | | | | | | | |
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| | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| | | 1 | | <u></u> | Page totals | 0 | 0 | 1 | 0 | 10 | 1 0 | 1 | 0 | 0 | 0 | 0 |

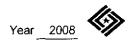
Be sure to transfer these totals to the Summary page (Form 300A) before you post it.

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Skin Disc

Page 1 of 1 (1) (2) (3) (4)

OSHA's Form 300A Summary of Work-Related Injuries and Illnesses



U.S. Department of Labor

Occupational Safety and Health Administration

1/2/2008

Form approved OMB no. 1216-0176

| | ered by Part 1904 must complete this Summary page, ex ng the year. Remember to review the Log to verify that th | | |
|--|--|--|---|
| | e individual entries you made for each category. Then w ded the entries from every page of the log. If you had no | | Establishment information |
| its entirety. They also h | oloyees, and their representatives have the right to review nave limited access to the OSHA Form 301 or its equival cordkeeping rule, for further details on the access provis | lent. See 29 CFR | Your establishment name CES Environmental Services Inc. Street 4904 Griggs Road |
| Number of Cases | | | City Houston State TX Zip 77021 |
| Total number of deaths | Total number of cases with days with job transfer or restriction 0 | Total number of other recordable cases | Industry description (e.g., Manufacture of motor truck trailers) Environmental services, tank cleaning, trucking Standard Industrial Classification (SIC), if known (e.g., SIC 3715) 1 5 4 2 |
| (G) Number of Days | (H) (6) | (J) | Employment information |
| Total number of days of job transfer or restriction 76 | Total number of days away from work 63 | | Annual average number of employees 132 Total hours worked by all employees last year 316,885 |
| (K) | (r) | _ | Total hours worked by an employees less year |
| Injury and Illness | | | Sign here |
| Total number of (M) (1) Injury (2) Skin Disorder | 4 (4) Poisoning (5) All other illnesses | 0 | Knowingly faisifying this document may result in a fine. |
| (3) Respiratory Condition | 0 | | I certify that I have examined this document and that to the best of my knowledge the entries are true, accurate, and complete. |
| | | | Company everytive Title |
| | | | |

Post this Summary page from February 1 to April 30 of the year following the year covered by the form

Rublic reporting burden for this collection of information is estimated to average 50 minutes per response, including time to review the instruction, search and gather the data needed, and complete and review the collection of information. Persons are not required to respond to the collection of information unless it displays a currently valid OMB control number. If you have any comments about these estimates or any aspects of this data collection, contact: US Department of Labor. OSHA Office of Statistics. Room N-3644. 200 Constitution Ave. NW. Washinaton, DC 20210. Do not send the completed forms to this office.

this office.

OSHA's Form 300 Log of Work-Related Injuries and Illnesses

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

City

Houston

Year 2008

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Form approved OMB no. 1218-0176

U.S. Department of Labor

Occupational Safety and Health Administration

State Texas

You must record information about every work-related injury or illness that involves loss of consciousness, restricted work activity or job transfer, days away from work, or medical treatment beyond first aid. You must also record significant work-related injuries and illnesses that are diagnosed by a physician or licensed health care professional. You must also record work-related injuries and illnesses that meet any of the specific recording criteria listed in 29 CFR 1904.8 through 1904.12. Feel free to use two lines for a single case if you need to. You must complete an injury and illness incident report (OSHA Form 301) or equivalent form for each injury or illness recorded on this form. If you're not sure whether a case is recordable, call your local OSHA office for help.

CES Environmental Services, Inc. Establishment name

| A) ase lo. | (B) Employee's Name | Ja | (C) b Title (e.g., Welder) | (D) Date of injury or | | (F) Describe injury or illness, parts of body affected, and object/substance that directly injured or made person ill | serious | nese categorie result for eac | | Y the most | the injured o | imber of days ir ill worker | Check the type of illa | ness: | • | | |
|------------------|--------------------------|----|----------------------------------|--|-----------------------------|---|---------|----------------------------------|------------------------|--|--|--|--|-------------------|-----------------|--|-------------------------|
| | | | reader, . | onset of illness (mo./day) | Coloning door not in Cally | (e.g. Second degree burns on right forearm from acetyler torch) | Death | from work | Remain Job transfer | ed af work Other record- able cases (J) | On job transfer or restriction (days) | Away from work (days) | (M) kinjul (1) | (5) Skin Disorder | (E) Respiratory | Bulasoning (4) | (g) All other illnesses |
| 1 | loaguinn Ramerez Alvarez | H | nkwash Tech | 1/24 | Tank Wash Bay 1 | Pain in hip, wrist, and hand from fall | | × | · | | 67 | 1 | x | | | | |
| _ | ebastian McCrimmons | - | iver | 5/6 | | Bums | | <u> </u> | | | 9 | | | × | 1 | | $\overline{}$ |
| | arrier Riley | | iver | 5/22 | | Cuts | 1 | × | | | · | 29 | х | | | | |
| 4 | arryl Johnson | - | arehouse Tec | 8/6 | South end of unloading dock | Heat stress | | x | | | i . | 1 | | | | | \Box |
| _ | cott Shimer | - | anager | 10/22 | Maintenance Shop | Cut | | | | | | | x | T | | | $\overline{}$ |
| 6 | David Vandenberg | | river | 11/3/08 | Newpark Env., Winnie, TX | Fracture | | × | | | | 32 | х | | | | |
| | | t | | | | | | | | | | | | | | | |
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| 1 | | | | · | | Page totals | 0 | 4 | 0 | 0 | 76 | 63 | 4 | 1 | 0 | 0 | 0 |

Public reporting burden for this collection of information is estimated to average 14 minutes per response, including time to review the instruction, search and gather the data needed, and complete and review the collection of information. Persons are not required to respond to the collection of information unless it displays a currently valid OMB control number. If you have any comments about these estimates or any aspects of this data collection, contact: US Department of Labor, OSHA Office of Statistics, Room N-3644, 200 Constitution Ave, NW, Washington, DC 20210. Do not send the completed forms to

1 of 1

(2)

(3)

JUAN MENDOZA

| · | icy Medical Data | 7 |
|--|---------------------------|--------------|
| Employee Emerger Employee Name: (5) (3) | PARRILLO | |
| Known Allergies: | | |
| Medical History: | | |
| Current Mo | edications Date Reported | Discontinued |
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| Employee Name: | (b) (4) | Castillo | <u></u> |
|------------------|---------------------------------------|---------------|--------------|
| Known Allergies: | | | |
| | NONE | | |
| Medical History: | | | |
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| | Current Med | lications | |
| Medication | | Date Reported | Discontinued |
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| Employee Name (4) Date of Birth: | Espinal | <u></u> |
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| Employee Name: Date of Birth: Known Allergies: | | |
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| Employee Name: | (DINIZALIES | A. LOE | |
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| Date of Birth: | b) '(4) | | |
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| Employee Emergency Medical Data |
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| Employee Name: Albert Hall Date of Birth: |
| Known Allergies: |
| ADNE |
| Medical History: |
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| Current Medications |

| Medication | Date Reported | Discontinued |
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| Employee Name Kameroz | Soalow | |
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| Date of Birth: (b) (4) | | |
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| Known Allergies: | | |
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| Medical History: | | |
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| Employee Name: | pel lope | 2 | |
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| Known Allergies: | | | |
| Medical History: ルかん | | | |
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| and the second of the second o | Current Me | edications | and a suppression of the superior of the super |
| Medication None | | Date Reported | Discontinued |
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| Employee Name: Date of Birth: | Ysow | |
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| Medical History: | | |
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Employee Emergency Medical Data Employee Name: Armondo P Rodriguez Date of Birth: __ Known Allergies: none I was Medical History: never sick none **Current Medications** Date Reported Discontinued Medication none П

| Employee Name: KR ESTO. Date of Birth | V SANDECS | |
|--|-----------------|----------------|
| Known Allergies: NONE | | |
| Medical History: | | · . |
| | ent Medications | |
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| Employee Emerge | ncy Medical Data | |
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| Employee Name: Date of Birth: | 100 | _ |
| Known Allergies: Now | | |
| Medical History: Hernea at ag | e 3 | |
| Asthma Curr | ent | |
| Current Me | edications | |
| Medication Primetine M: 5+ | Date Reported Since Birth | Discontinued |
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| Employee Emergenc | y Medical Data | |
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| Employee Name: Employee Name: Date of Birth: | MIEN JR | <u> </u> |
| Known Allergies: | | |
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| Medical History: | | |
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| Employee Name: Date of Birth: Known Allergies: | Sittig | |
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| Medical History: | | |
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Employee Emergency Medical Data Employee Name: Date of Birth: _ Known Allergies: Medical History: NO TEETH - DENTURES **Current Medications** Date Reported Medication Discontinued

| Employee Name: Date of Birth: | cker | <u> </u> |
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| Known Allergies: | | |
| Madical History | | |
| Medical History: | | |
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Employee Name: Ray mon No Date of Birth Known Allergies: Medical History: **Current Medications** Medication Date Reported Discontinued

| Employee Name: (1) A (1) (1) Date of Birth: | 1 madenberg | |
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| Known Allergies: | е | |
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| Medical History: | TiegHigh Bloodp | nressure |
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| Employee Name: _ Date of Right: | Edward . | A. Luniga | |
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| Date of Birth: | (b) (4) — | | |
| T7 411 * | | | |
| Known Allergies: | | | |
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| Medical History: | | | |
| None | | | |
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| Medication, | | Date Reported | Discontinued |
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8-22-08 Benjamin Mota had a blown infaner
2 2:30pm tike-that hit a 3th party can causing damage to the fender. Greg althrized the paint \$ 605.53.

293 Rear right inner tirk blew up ad hit 261 Junction I 10 west & at Baylown

9-3-08 Edwin Barrientos picked up check to \$ 605.53 today after righing the Rehease in full do current

| CES ENVIRONMENTAL SERVICES, INC. 4904 GRIGGS ROAD | BANK OF AMERICA, NA 35-2/1130 | 40022 |
|--|----------------------------------|-----------------------------------|
| HOUSTON, TEXAS 77021 (713) 676-1460 | | 8/31/2008 |
| Edwin Barrientos PAYTO THE ORDER OF | | \$** 605.53 |
| Six Hundred Five and 53/100*********************************** | ************* | DOLLARS 🖰 🔙 |
| Edwin Barrientos | | |
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| MEMO repairs | Tritt Bo | war - |
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| CES ENVIRONMENTAL SERVICES, INC. Edwin Barrientos | 8/31/2008 | 3 40022 605.53 |
| repairs on 200 VIN# 5TENL42 | 1 Toyota Tacoma 2N51Z865304 | make the first term of the second |

CES Environmental S repairs

605.53

Probaker (b) (4)

RELEASE IN FULL

WHEREAS, Edwin Barrientos ("Releasor") and / or Releasor's 2001 Toyota Tacoma was allegedly injured / damaged from flying debris from a flat tire of CES Environmental Services, Inc. Unit 293 allegedly caused by CES Environmental Services, Inc. driver Benjamin Mata on or about August 22, 2008;

WHEREAS, Releasor desires to settle and release any and all injuries and / or damages allegedly sustained by Releasor in any way arising from the above referenced incident or otherwise;

NOW THEREFORE, for good and valuable consideration, the receipt of which is hereby acknowledged, Releasor does hereby acquit and forever discharge CES Environmental Services, Inc. along with its affiliate companies, and / or their officers, directors, employees, agents and / or assigns (collectively hereinafter referred to as "Releasee"), from any and all claims, demands, damages, actions and causes of action arise, by reason of, or in any manner having grown out of injuries, incident (regardless whether such injuries or damages were caused in whole or in part by the negligent or intentional acts of any person or entity being released hereunder).

The parties agree that this Release is a full, final and complete release of Releasee of any and all matters and things described herein and agree, without limitation, that Releasor releases the consequences of Releasee's own negligence, whether that negligence is the sole or a concurring cause of the injury or damage allegedly suffered by Releasor.

Releasor expressly agrees, understands and declares that all agreements and understanding between Releasor and Releasee are embodied and expressed herein, that no representations or statements made by Releasee has influenced or induced Releasor to execute this Release, and that no part of any cause of action hereby released has been transferred or assigned to anyone. Releasor represents, covenants and warrants that he has full and complete power and authority to execute this instrument.

The payment of \$ 605.53 to Releasor is not to be construed as an admission of liability, which has been denied. This agreement is governed by the laws of the State of Texas, without regards to its conflicts of laws rules. It is performable in Harris County, Texas.

| Excedited this day of | 2008. |
|-----------------------|-------------------------|
| Releasor | |
| EUDB - | Poblut Thyon Witness |
| Address: (b) (4) | Witness |
| | |
| | |

down SP. PLY MRCR

Evacuted this

JIMMY'S PAINT & BODY SHOP 1235 NORMANDY HOUSTON, TX 77015 713-453-2712

CD LOG NO 1952-1 DATE 08/27/08

SHOP:

JIMMYS PAINT & BODY SHOP

INSP DATE:

08/27/08

ADDRESS:

1235 NORMANDY

ZIP:

CITY STATE: HOUSTON, TX

77015-

OWNER:

BARRIENTOS, EDWIN

POINT OF IMPACT: 0

LIC#:

STATE:

VIN:

MILEAGE:

BODY COLOR: CONDITION:

ACCING CTL#:

*=USER-ENTERED VALUE EC=REPLACE ECONOMY

UM=REMAN/REBUILT PRT OE=REPLACE PXN OE SRPLS

TE=PARTL REPL PRICE I=REPAIR

TT=TWO-TONE

N=ADDITIONAL LABOR AA=APPEAR ALLOWANCE E=REPLACE OEM

UE=REPLACE OE SURPLUS EU=REPLACE SALVAGE

PC=PXN RECONDITIONED ET=PARTL REPL LABOR

L=REFINISH CG=CHIPGUARD

RI=R&I ASSEMBLY RP=RELATED PRIOR NG≃REPLACE NAGS

UC=RECONDITIONED PRT

EP=REPLACE PXN

PM=PXN REMAN/REBUILT IT=PARTIAL REPAIR BR=BLEND REFINISH

SB=SUBLET P=CHECK

UP=UNRELATED PRIOR

2001 TOYOTA TACOMA STD 2DOOR STANDARD CAB 4CYL GASOLINE 2.4

Y8122A/G OPTNS A/24

OPTIONS:

TWO-STAGE - EXTERIOR SURFACES

TWO-STAGE - INTERIOR SURFACES

| ΟP | GDE | MC | DESCRIPTION | | MFG.PART NO. | PRICE | AJ% B% | HOURS R |
|--------------|------|-----------|----------------------|---------------------|----------------|---------|--------|---------|
| | | - | | | | | | |
| EC | 0103 | 01 | FENDER, FRONT | $_{ m LT}$ | ECONOMY PART | 109.00* | | 2.5 1 |
| \mathbf{L} | 0103 | 13 | FENDER, FRONT | LT | REFINISH | | | 3.8 4 |
| BR | 0207 | | DOOR SHELL, FRONT | LT | BLEND REFINISH | | | 1.3 4 |
| RI | 0169 | | W/STRIP, BELT OUTER | LT | R&I ASSEMBLY | | | 0.2 1 |
| RI | 0150 | | N/PLATE, FRONT DOOR | LT | R&I ASSEMBLY | | | 0.2 1 |
| RΙ | 0161 | | HANDLE, FRONT DOOR O | $_{ m LT}$ | R&I ASSEMBLY | | | 0.6 1 |

6 ITEMS

MC MESSAGE(S)

01 CALL DEALER FOR EXACT PART NUMBER / PRICE

13 INCLUDES 0.6 HOURS FIRST PANEL TWO-STAGE ALLOWANCE

FINAL CALCULATIONS & ENTRIES OTHER PARTS

109.00

PAGE 1

2001 TOYOTA TACOMA STD 2DOOR STANDARD CAB CD LOG NO 1952-1

| | | 0 2500 | 132.60 241.60 19.93 |
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| . <i>a</i> | | 8.2308 | 19.93 |
| RATE | REPLACE HRS | REPAIR HRS | |
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SHOPLINK UI098 ES CD LOG 1952-1 DATE 08/27/08 11:11:33AM R6.37 CD 06/08 HOST LOG

- (C) 1998 2007 AUDATEX NORTH AMERICA, INC.
- 1.5 HRS WERE ADDED TO THIS EST. BASED ON AUDATEX TWO-STAGE REFINISH FORMULA.

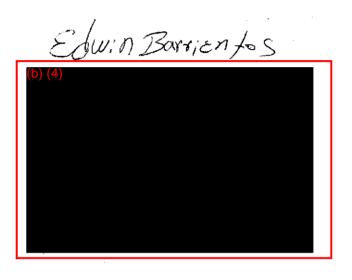
Avg 22, 2008

CES ENVIRONMENTA:

SERVICES

HOUSFORTX 77021

713-676-146H BENJAMINI NOELIA - MATAS



I was in the middle lane and there was a small toyota truck on the right lane, one of the inside back axle tire exploded, a pice of the recap hit the left signal lights and broke it and also the front fender.

Benjamon Mata.



Job Number:

BATES CUSTOM COLLISION NORTH CHANNEL

Federal ID #:481290125 15532 I-10 East Channelview, TX 77530

(281) 452-9100 Fax: (281) 452-9200

PRELIMINARY ESTIMATE

Written By: Bates Custom & Collision Adjuster:

Address: Deductible: Date of Loss:

Day: Type of Loss:

Evening: Point of Impact:

Inspect Location:

Insurance

Company: Days to Repair

2001 TOYO TACOMA 4X2 4-2.4L-FI 2D P/U Int:

VIN: (b) (4) Prod Date: Odometer:
Intermittent Wipers Dual Mirrors Clear Coat Paint

Power Steering Power Brakes AM Radio
FM Radio Stereo Search/Seek
Driver Air Bag Passenger Air Bag Cloth Seats

5 Speed Transmission Overdrive

| NO. | OP. | DESCRIPTION | QTY | EXT. | PRICE | LABOR | PAINT |
|------------|--------|-----------------------------|-----|------|-------|---|-------|
| 1 | | FRONT BUMPER | | | | der Minch spelft depth began sprage speed s | |
| 2 | R&I R | &I bumper assy | | | | 1.0 | |
| 3 | | FRONT LAMPS | | | | | |
| 4 | R&I L | T Park/marker lamp standard | | | | Incl. | |
| 5 | | HOOD | | | | | |
| 6 | Blnd H | ood | | | | | 1.3 |
| 7 | | WINDSHIELD | | | | | |
| 8 | R&I W | asher nozzle | | | | 0.2 | |
| 9 | | FENDER | | | | | |
| 10 | Repl L | T Fender all w/o flares | 1 | 257. | 12 | 1.5 | 2.2 |
| 11 | A | dd for Clear Coat | | | | | 0.9 |
| 12 | A | dd for Edging | | | | | 0.5 |
| 13 | A | dd for Clear Coat | | | | | 0,1 |
| <u>~</u> 4 | Ð | educt for Overlap | | | | -0.4 | |

PRELIMINARY ESTIMATE 2001 TOYO TACOMA 4X2 4-2.4L-FI 2D P/U Int:

| NO. | OP. | DESCRIPTION | | EXT. | PRICE | LABOR | PAINT |
|-------------|------|--|----|-------|--------|----------|-------------|
| 15* | | LT Apron assy left side all | | | | 1.5 | 1.0 |
| 16# | Rpr | BODY PULL | | | | 2.0 F | |
| 17 | | FRONT DOOR | | | | | |
| 18* | Rpr | LT Outer panel | | | | 2.5 | 2.3 |
| 19 | | Overlap Major Adj. Panel | | | | | -0.4 |
| 20 | | Add for Clear Coat | | | | | 0.4 |
| 21 | Repl | LT Nameplate "TOYOTA TACOMA" chrome | 1 | 30 | .47 | 0.3 | |
| 22 | R&I | LT Mirror assy manual silver | | | | 0.5 | |
| 23 | | LT Handle, outside w/c body color w/o chrome | | | | 0.3 | |
| 24 | R&I | LT R&I trim panel | | | | 0.4 | |
| 25# | Refn | COVER CAR EXTERIOR | | | | | 0.5 |
| 26# | Refn | CORROSION PROTECTION | | | | | 1.0 |
| 27 # | | HAZARDOUS WASTE REMOVAL | | | .00 X | | |
| | | Subtotals ==> | | | .59 | 9.8 | 9.8 |
| | | Parts | | | | | 287,59 |
| | | Body Labor | 7. | 8 hrs | 3 Q S | 40.00/hr | |
| | | - | | | | 40.00/hr | |
| | | Frame Labor | | | | 60,00/hr | |
| | | Paint Supplies | | | | | |
| | | Sublet/Misc. | | | | · | 5.00 |
| | | SUBTOTAL | | | | \$ | 1390.99 |
| | | Sales Tax | \$ | 561 | 1.99 @ | 6.2500% | |
| | | GRAND TOTAL | | | | | 1426.11 |

We are please to provide this estimate of repair cost, it will be honored for 30 days. Parts costs are subject to verification of cost with manufactor invoice. Once your vehicle is brought in for repairs, upon dissasembly we may find hidden or additional damage, you will be contacted immediately for authorization prior to proceeding.

Job Number:

PRELIMINARY ESTIMATE

2001 TOYO TACOMA 4X2 4-2.4L-FI 2D P/U Int:

Estimate based on MOTOR CRASH ESTIMATING GUIDE. Unless otherwise noted all items are derived from the Guide ARM8510, CCC Data Date 07/01/2008, and the parts selected are OEM-parts manufactured by the vehicles Original Equipment Manufacturer. OEM parts are available at OE/Vehicle dealerships. OPT OEM (Optional OEM) or ALT OEM (Alternative OEM) parts are OEM parts that may be provided by or through alternate sources other than the OEM vehicle dealerships. OPT OEM or ALT OEM parts may reflect some specific, special, or unique pricing or discount. OPT OEM or ALT OEM parts may include "Blemished" parts provided by OEM's through OEM vehicle dealerships. Asterisk (*) or Double Asterisk (**) indicates that the parts and/or labor information provided by MOTOR may have been modified or may have come from an alternate data source. Tilde sign (~) items indicate MOTOR Not-Included Labor operations. Non-Original Equipment Manufacturer aftermarket parts are described as AM, Qual Repl Parts or Comp Repl Parts which stands for Competitive Replacement Parts. Used parts are described as LKQ, Qual Recy Parts, RCY, or USED. Reconditioned parts are described as Record. Record parts are described as Recore. NAGS Part Numbers and Benchmark Prices are provided by National Auto Glass Specifications. Labor operation times listed on the line with the NAGS information are MOTOR suggested labor operation times. NAGS labor operation times are not included. Pound sign (#) items indicate manual entries. Some 2006 vehicles contain minor changes from the previous year. For those vehicles, prior to receiving updated data from the vehicle manufacturer, labor and parts data from the previous year may be used. The Pathways estimator has a complete list of applicable vehicles. Parts numbers and prices should be confirmed with the local dealership.

CCC Pathways - A product of CCC Information Services Inc.

Greganthorized Pryment of \$275 for windshield repairs on 6-10-09



AIG Domestic Claims, Inc. Property/Casualty Division

P.O. Box 25588

Shawnee Mission, KS 66225 (800) 242-2987

(all other) Fax (866) 723-0109 (new losses) Fax (866) 854-4926

AUTOMOBILE LIABILITY **CLOSED CLAIM NOTICE**

June 4, 2009

CES ENVIRONMENTAL 4904 GRIGGS RD HOUSTON, TX 77021-3208 Attn: GREG BOWMAN

RE:

Insured

: CES ENVIRONMENTAL SERVICES INC

Carrier

: Commerce & Industry

Date of Loss

: 05/18/2009

Date Reported

: 05/29/2009

Claim Number

(b) (4)

Date Received

:05/29/2009

The above captioned claim has been closed. The following amounts were paid on the claim:

Symbol Claimant

001 JUDY RILLEY

MJC Indemnity 007

Medical

Legal

ADDITIONAL CLAIM INFORMATION:

Policy Number

: 005062132

Loss Location

: I-45 BETWEEN BAY AREA & FUGUA HOUSTON.TX

Description of Loss

: CLMT ALLEGES THAT A ROUND PIECE OF METALCAME OFF OF I/V VEH AND

HIT HER VEH

Insured Driver

: UNKNOWN UNKNOWN

RISK ANALYSIS INFORMATION:

| Level 1: | |
|----------------------|--|
| Level 1: Level 2: | |
| Level 3: | |
| Level 4: | |
| Level 5: | |
| Level 6: | |

Thank you for allowing us to serve you on this claim. Please contact me if you have any questions or comments.

Sincerely, RODGER MOSIMAN FAST TRACK REP 251-PC OVERLAND PARK, KS

(913) 338-9301

RODGER.MOSIMAN@AIUHOLDINGS.COM

Original

P Pls comminitate

that this issue is complete.

Document Break



Donald Brzemen Truck accident 6-23-2009

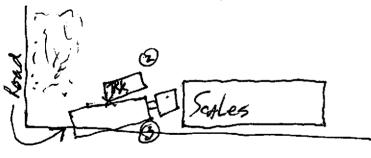
17

5 F

EPAHO042001662

ACCIDENT DESCRIPTION

| LWAS coming in to | so on Septer at Alast |
|-------------------------|--------------------------|
| I saw the Thuck or | 2 my Lett side next |
| | cut wide to my Right |
| to clear TRuck by th | - Time my mirkon got |
| around to where I can | |
| | metal hanging down |
| | 43 which cought the |
| | 1 / W/LIV CLEROSIA 1 V V |
| | |
| light side of the Top e | dge of the Thick When a |
| hight side of the Top e | dge of the Thuk when a |
| light side of the Top e | dge of the Thuk when a |
| hight side of the Top e | dge of the Thuk when a |



| | WITNESSES |
|-------|-----------|
| Nove | |
| Name | Address |
| Phone | Workplace |
| Name | Address |
| Phone | Workplace |

DRIVER'S REPORT AT ACCIDENT SCENE

| Checklist |
|---|
| Stop and Investigate |
| Set Warning Devices |
| Help the Injured |
| Protect Your Vehicle and Cargo from Theft and Further Damage |
| Do Not Move Your Vehicle Until Police Arrive |
| Contact Supervisor as Soon as Possible. (Use accident notification card if you can't leave) |
| Discuss Accident Only with Proper Authorities |
| Obtain Names and Addresses of Witnesses. (Use witness cards supplied) |
| Complete This Card At the Scene of Accident |
| Comply With Any Required Alcohol/Drug Test |

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ENTIRE

_ RETURN

SUPERVISOR

33F-2 Rev. 12/99 RM 5815

PACKET

| DRIVER | YOUR VEHICLE |
|---|--|
| ACCIDENT DATA | Were any mechanical defects apparent at the time of the accident? Explain |
| Date 6-23-69 Time / \$2.5 ☑ P.M. | |
| Place Siales LA | |
| (Town, City, State) | Were you wearing safety belts? |
| (Rt. #, Street, Intersecting Hwys) | VEHICLE NO. 2 |
| Landmark / Siz Les Scales (Near bridge, milepost, etc.) | Type Ford F-150 Make Ford F-150 |
| | Model Ford F-150 Year 05 |
| DEATH AND INJURY | Driver GARCIA GRAVIEL |
| Persons Killed Ylong | Address (b) (4) |
| | |
| Persons Injured | License # & State (b) (4) |
| Was anyone taken away from scene for medical | Owner Instrumentation & Electrical Specialis |
| treatment (Who & Where Taken) | Address 2417 Randolph , LLC PASAden & Tx. 7503 |
| | Phone (b) (4) Phone Prance Co. Amt Security Nation |
| | |
| | VEHICLE NO. 3 |
| Was Accident Investigated by Police? | Type Make |
| Department Badge # | Model Year |
| Officer | Driver |
| Citation Issued? | Address |
| List persons cited or arrested & charges | |
| | License # & State |
| | Owner |
| | Address |
| | Phone Insurance Co. |

Instrumentation & Electrical Specialist, LLC.

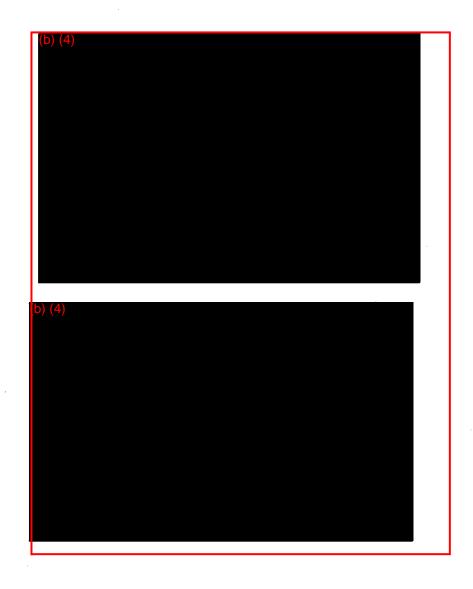


Gabe Garcia

2417 Randolph Pasadena, TX 77503 ggarcia@iespecialist.com

TECL 17031

Fax 281-470-1067 Cell 832-250-4568



INSURANCE IDENTIFICATION CARD

STATE TX

NY NUMBER

COMPANY

AMT-Security National

Y NUMBER

EFFECTIVE DATE

EXPIRATION DATE

1002484

12/16/08

12/16/09

MAKE/MODEL

7 Ford F150 Y/COMPANY ISSUING CARD

VEHICLE IDENTIFICATION NUMBER

tory Insurance Agency, Inc. er Montemayor, CIC -485-7500 JRED

Instrumentation & Electrical Specialist, LLC P.O. Box 5370 Pasadena

TX 77508-5370

COVERAGE MEETS MINIMUM LIABILITY INSURANCE PRESCRIBED BY LAW

OP ID 15

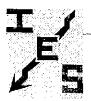
THIS CARD MUST BE KEPT IN THE INSURED VEHICLE AND PRESENTED UPON DEMAND

IN CASE OF ACCIDENT: Report all accidents to your Agent/Company as soon as possible. Obtain the following information:

- 1. Name and address of each driver, passenger and witness.
- 2. Name of Insurance Company and policy number for each vehicle involved.

50 (1/83)

EPAHO042001667



FLEET/ACCIDENT/INCIDENT/OCCURRENCE INVESTIGATION MANAGERS REPORT

THIS FORM MUST BE COMPLETED IN INK

| NAME OF OUR Gabe | Genera BIRTH | HOME (b) (4) ADDRESS | | HOME (5) (4) PHONE |
|---|--|----------------------------|-------------------|---------------------------------------|
| DRIVER'S LICENSE # | | EXPIRATION | DATE | |
| LOCATION OF ACCIDENT OCCURRENCE By gle. | Truck Luading SC | ales | DATE 6/23/09 | HOUR 1530 KM |
| | 4 MPH VEHICLE | | | |
| FLEET LIC UNIT # 253 AN | Sunny & Clear CENSE PLATE # Texas, ND YEAR | R88-009 DAMAGE | ly Poscerase | 5: Le Reas |
| DATE, LOCATION, BADGE # AND OTHER | D NAME OF POLICE AND MUNICIP | ALITY TO WHOM ACCIDENT/INC | EIDENT/OCCURRENCE | WAS REPORTED |
| PHONE 7/3/676- / | S Environ mental 5 | - 6 | 'S LICENSE# | 4) |
| OTHER VEHICLESS A | nald William Boz | | | |
| · · · · · · · · · · · · · · · · · · · | RIPTION (MAKE, MODEL, C TATE RES - CO9 | · . | | Sca 3 23 |
| DAMAGE | , | - 1 Suc | | · · · · · · · · · · · · · · · · · · · |
| WAS OTHER VEHICLE(S) | INSURED? Yes NAME | | | |
| | IAGE OR PERSONAL INJUI TION OF PROPERTY DAMA | 7.1 | Interations | d Group |
| INJURED PERSONS: | | | | |
| NAME: | ADDRESS: | PHONE; | . TYP. | E OF INJURY: |
| | | | | |
| WITNESS: | Ex | | | |
| NAME: | ADDRESS: | HOME PE | IONE: WOI | RK PHONE: |
| ACCIDENT/INCIDENT/O | CCURRENCE DETAILS-exa | ctly what happened: | The IES | Touck was |
| togled by the | Truck Scales (| (CES frust with | des Jong | the weigh |
| | | | | |
| THIS REPORT | MUST BE SUSPMITTED OF | | DENTY/ALCTO ENTE | CCIPPENCE |



TO BE GIVEN TO THE OPERATOR OF THE OTHER VEHICLE

YOU MAY CONTACT

THE

I.E.S. ADMINISTRATOR

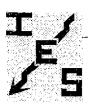
AT

2417 RANDOLPH, PASADENA, TEXAS 77503

(281) 470-1063

BETWEEN THE HOURS OF 8:00 a.m. - 5:00 p.m.

MONDAY - FRIDAY



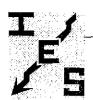
COMPLETE RELEASE OF LIABILITY

TO WHOM IT MAY CONCERN:

I hereby release, acquit and forever discharge the Instrumentation & Electrical Specialist, L.I. employee operating the vehicle involved in the accident/incident or involved in the incident occurrence described below, Instrumentation & Electrical Specialist, L.L.C. and any and all ot persons, firms, organizations, and corporations from any and all damages, losses, causes of acti expenses, claims, demands and liability of whatever kind of character, arising out of a vehicu accident or any occurrence or incident involving Instrumentation & Electrical Specialist, L.L.C. or employee thereof.

| Accident/Incident/Occurrence Description: (ES Touck has an IES | |
|--|---|
| truck parked near the truck scales at Bigler Terminals | |
| | |
| Accident/Incident/Occurrence Date: 6-23-09 | |
| Accident/Incident/Occurrence Time: 1530 | |
| Accident/Incident/Occurrence Location: Biger truck scales | |
| Instrumentation & Electrical Specialists' Employee Name: Gale Garcia | _ |
| | |
| Releasee Printed Name: William Agnalal Buzeman | |
| Releasee Home Address: (b) (4) | |
| | |
| Releasee Business Phone Number: 1/3 -676-1460 | _ |
| Releasee Home Phone Number: (b) (4) | |
| | |
| Releasee Signature: Donald W. Bozeman 6-23-09 | |
| | |

PLEASE RETURN THIS FORM TO THE I.E.S. EMPLOYEE
THANK YOU



PROPERTY DAMAGE RELEASE OF LIABILITY

TO WHOM IT MAY CONCERN:

I hereby release, acquit and forever discharge the Instrumentation & Electrical Specialist, L.L. employee operating the vehicle involved in the accident/incident or involved in the incident occurrence described below, Instrumentation & Electrical Specialist, L.L.C. and any and all oth persons, firms, organizations, and corporations from any and all damages, losses, causes of actic expenses, claims, demands and liability of whatever kind of character, arising out of a vehicul accident or any occurrence or incident involving Instrumentation & Electrical Specialist, L.L.C. or employee thereof.

| Accident/Incident/Occurrence Description: CES Truck hit an IES | Truc |
|--|------|
| that was parked near the Bigler Truck scale. | |
| Accident/Incident/Occurrence Date: 6-23-09 | · |
| Accident/Incident/Occurrence Time: 15.30 | |
| Accident/Incident/Occurrence Location: Bigler Trues Scales Instrumentation & Electrical Specialists' Employee Name: Gabe Garcia | · |
| Instrumentation & Electrical Specialists' Employee Name: Gabe Garcia | |
| | |
| Releasee Printed Name: William Donald Bozeman | |
| Releasee Home Address: (b) (4) | |
| | · |
| Releasee Business Phone Number: 7/1-11/-14/60 | |
| Releasee Home Phone Number: | |
| Releasee Signature: Donald W. Bozeman 6-23-09 | |

PLEASE RETURN THIS FORM TO THE I.E.S. EMPLOYEE
THANK YOU



BODILY INJURY DAMAGE RELEASE OF LIABILITY

TO WHOM IT MAY CONCERN:

I hereby release, acquit and forever discharge the Instrumentation & Electrical Specialist, L.L. employee operating the vehicle involved in the accident/incident or involved in the incident occurrence described below, Instrumentation & Electrical Specialist, L.L.C. and any and all oth persons, firms, organizations, and corporations from any and all damages, losses, causes of action expenses, claims, demands and liability of whatever kind of character, arising out of a vehicular accident or any occurrence or incident involving Instrumentation & Electrical Specialist, L.L.C. or employee thereof.

| Accident/Incident/Occurrence Description: CES love Kit an IES |
|--|
| truck that was parked near the truck scales at |
| truck that was parked near the truck scalos at Bigle Terminals |
| Accident/Incident/Occurrence Date: 6-23-09 |
| Accident/Incident/Occurrence Time: |
| Accident/Incident/Occurrence Location: Digler Truck scales |
| Instrumentation & Electrical Specialists' Employee Name: Gabe Garcia |
| Releasee Printed Name: Donald William Bozeman |
| Releasee Home Address: (b) (4) |
| Releasee Business Phone Number 7/3-646-1469 |
| Releasee Home Phone Number: |
| Releasee Signature: Donald W. Bozeman 6-23-69 |

PLEASE RETURN THIS FORM TO THE I.E.S. EMPLOYEE
THANK YOU



WITNESS IDENTIFICATION

| Accident/Incident/Occurrence Description: LES Environmental Sources |
|---|
| truck his the year passenger side of my IES Truck |
| IES truck was parked near the truck scale i |
| Accident/Incident/Occurrence Date: 6-23-69 |
| Accident/Incident/Occurrence Time: 1530 |
| Accident/Incident/Occurrence Location: Bigler Truck Scales |
| Did you see the accident/incident/occurrence? No |
| Did anyone appear injured? No |
| Were you riding in a vehicle involved? |
| If yes, which one? |
| Who do you think was responsible? CES ENVIronmental Services |
| WITNESS INFORMATION Printed Name: Home Phone: () |
| Home Address: |
| Business Phone: () Pager: () |
| Mobile Phone: () |
| Witness Signature: |

PLEASE RETURN THIS FORM TO THE I.E.S. EMPLOYEE THANK YOU



ACCIDENT/INCIDENT/OCCURRENCE INFORMATION EXCHANGE FORM FOR THE OTHER PARTY

| ACCIDENT/INCIDENT/OCCURRENCE DESCRIT | PION: CES EMVICON MENT SERVICES |
|--|---------------------------------|
| ACCIDENT/INCIDENT/OCCURRENCE DATE: | 6-23-69 |
| ACCIDENT/INCIDENT/OCCURRENCE TIME: | 1530 |
| ACCIDENT/INCIDENT/OCCURRENCE LOCATIO | DN: Bigler Truck Scales |
| DRIVER'S INFORMATION NAME: Donald William Bozeman | (b) (4) PHONE NUMBER |
| LICENSE #: | STATE: <u>Texás</u> |
| HOME ADDRESS: _ (b) (4) | |
| | ZIP: |
| WITNESS INFORMATION NAME: | HOME PHONE: () |
| HOME ADDRESS: | |
| BUSINESS PHONE: () | PAGER: () |
| MOBILE PHONE: () | • |
| LIABILITY INSURANCE INFORMATION INSURANCE COMPANY NAME:America | in International Group |
| Agency: Insurance Alliance | PHONE NUMBER: (312) 930-5403 |
| | |
| POLICE INFORMATION INVESTIGATING OFFICER'S NAME: | BADGE NO. |
| POLICE AGENCY NAME (HARRIS CTY, HPD, DI | PS, etc.) |

PLEASE RETURN THIS FORM TO THE I.E.S EMPLOYEE. THANK YOU.

 ${\bf Instrumentation~\&~Electrical~Specialist, LLC.}$



2417 Randolph Pasadena, TX 77503 ggarcia@iespecialist.com

TECL 17031 C

Fax 281-470-1067 Cell 832-250-4568

POST ACCIDENT TESTING DETERMINATION

| Driver's Name: Dan & A hovemon | ID: Facility: | Biales | · · |
|--|--|--|--|
| Date of Accident: 6-23-09 Time of Ac | cident: 1525 Location | n Digher LP | Phont |
| Time Driver Instructed to be Tested: | 1 | er was Tested: | |
| Does vehicle meet the definition of a comme | | YES INO | |
| If no, do NOT conduct a DOT Drug or Alco | | | |
| If yes, check the type of commercial motor | | | |
| ☐ Vehicle has a gross combination weight rating gross vehicle weight rating of more than 10,00 | of 26,001 or more pounds inclusive o | f a towed unit with a | |
| □ Vehicle has a gross vehicle weight rating of 26 | • | | • |
| □ Vehicle is designed to transport 16 or more pa | • | | |
| ☐ Vehicle is of any size and is used in the transp | | ng placards. | |
| · | ing a CMV, did accident involute a DOT Drug and Alcohol Test | • | |
| (IF NO) | | | |
| | | | |
| ** Did the driver | INJURY Did anyone receive | | |
| receive a citation? | immediate medical treatment away from | > <u>YES</u> | * DOT Drug & Alcohol Test Required |
| Chauon: | the scene of the accident? | | · |
| | accident: | | |
| NO | NO | | |
| Do NOT conduct a | | | |
| DOT Drug or Alcohol Test. | | | |
| | DAMAGES | | * DOTD-10 % Al-shall |
| < | Did any vehicle incur disabling damages? | > <u>YES</u> | * DOT Drug & Alcohol Test Required |
| | distanting samingers | | |
| | | | NOTES |
| | NO | * Test must be condu test within 8 hours; d | cted immediately alcohol rug test within 32 hours. |
| | | ** A DOT Alcohol T | est is not authorized if the ve a citation within 8 hours. |
| | Do NOT conduct a DOT Drug or | ** A DOT Drug Test | is not authorized if the driver |
| | Alcohol Test, | does not receive a cit | ation within 32 hours. |
| | | | |
| ☐ It was determined that a DOT Drug & Alcohol Tes | t was not necessary for the following i | reasons: | |
| ☐ It was determined that a DOT Drug & Alcohol Tes | t was necessary for the following reason | ons: | |
| If an alcohol test was not completed within 2 hours, p | | | |
| If a drug test was not completed within 32 hours, prov | | | |
| Completed By: | | | |
| Name Copyright 2004 J. J. KELLER & ASSOCIATES INC. Neemah, WL+1-800-327-886 | Title | | 522-E 0272 |

ATTENTION: DRIVER'S INVOLVED IN A MOTOR VEHICLE ACCIDENT

Review this Part of the Department of Transportation regulations for compliance with alcohol and controlled substance testing post-accident requirements.

§382.303 Post-accident testing.

(a) As soon as practicable following an occurrence involving a commercial motor vehicle operating on a public road in commerce, each employer shall test for alcohol for each of its surviving drivers:

(1) Who was performing safety-sensitive functions with respect to the vehicle, if the accident involved the loss of human

life; or

- (2) Who receives a citation within 8 hours of the occurrence under State or local law for a moving traffic violation arising from the accident, if the accident involved:
- (i) Bodily injury to any person who, as a result of the injury, immediately receives medical treatment away from the scene of the accident; or
- (ii) One or more motor vehicles incurring disabling damage as a result of the accident, requiring the motor vehicle to be transported away from the scene by a tow truck or other motor vehicle.
- (b) As soon as practicable following an occurrence involving a commercial motor vehicle operating on a public road in commerce, each employer shall test for controlled substances for each of its surviving drivers:
- (1) Who was performing safety-sensitive functions with respect to the vehicle, if the accident involved the loss of human life; or
- (2) Who receives a citation within thirty-two hours of the occurrence under State or local law for a moving traffic violation arising from the accident, if the accident involved:
- (i) Bodily injury to any person who, as a result of the injury, immediately receives medical treatment away from the scene of the accident; or
- (ii) One or more motor vehicles incurring disabling damage as a result of the accident, requiring the motor vehicle to be transported away from the scene by a tow truck or other motor vehicle.
- (c) The following table notes when a post-accident test is required to be conducted by paragraphs (a)(1), (a)(2), (b)(1), and (b)(2) of this section:

| TABLE FOR §382.303 (A) AND (B) | | | |
|--|---|------------------------------------|--|
| Type of accident involved | Citation is- sued to the CMV driver | Test must be performed by employer | |
| i. Human fatality | YES | YES | |
| | NO | YES | |
| ii. Bodily injury with immediate medical treatment away from the scene | YES | YES | |
| treatment away from the scene | NO | NO | |

| TABLE FOR §382.303 (A) AND (B) | | | |
|--|---|------------------------------------|--|
| Type of accident involved | Citation is- sued to the CMV driver | Test must be performed by employer | |
| iii. Disabling damage to any motor vehicle requiring tow away | YES | YES | |
| | NO | NO | |

- (d)(1) **Alcohol tests.** If a test required by this section is not administered within two hours following the accident, the employer shall prepare and maintain on file a record stating the reasons the test was not promptly administered. If a test required by this section is not administered within eight hours following the accident, the employer shall cease attempts to administer an alcohol test and shall prepare and maintain the same record. Records shall be submitted to the FMCSA upon request.
- (2) Controlled substance tests. If a test required by this section is not administered within 32 hours following the accident, the employer shall cease attempts to administer a controlled substances test, and prepare and maintain on file a record stating the reasons the test was not promptly administered. Records shall be submitted to the FMCSA upon request.
- (e) A driver who is subject to post-accident testing shall remain readily available for such testing or may be deemed by the employer to have refused to submit to testing. Nothing in this section shall be construed to require the delay of necessary medical attention for injured people following an accident or to prohibit a driver from leaving the scene of an accident for the period necessary to obtain assistance in responding to the accident, or to obtain necessary emergency medical care.

(f) An employer shall provide drivers with necessary postaccident information, procedures and instructions, prior to the driver operating a commercial motor vehicle, so that drivers will be able to comply with the requirements of this section.

(g)(1) The results of a breath or blood test for the use of alcohol, conducted by Federal, State, or local officials having independent authority for the test, shall be considered to meet the requirements of this section, provided such tests conform to the applicable Federal, State or local alcohol testing requirements, and that the results of the tests are obtained by the employer.

(2) The results of a urine test for the use of controlled substances, conducted by Federal, State, or local officials having independent authority for the test, shall be considered to meet the requirements of this section, provided such tests conform to the applicable Federal, State or local controlled substances testing requirements, and that the results of the tests are

obtained by the employer.

(h) Exception. This section does not apply to:

(1) An occurrence involving only boarding or alighting from a stationary motor vehicle; or

(2) An occurrence involving only the loading or unloading of

(3) An occurrence in the course of the operation of a passenger car or a multipurpose passenger vehicle (as defined in §571.3 of this title) by an employer unless the motor vehicle is transporting passengers for hire or hazardous materials of a type and quantity that require the motor vehicle to be marked or placarded in accordance with §177.823 of this title.

CES Environmental Services, Inc.

INCIDENT REPORT

| Near Miss | · | | Acc | ident |
|-------------------------------------|---------------------|-----------------------|--|--------------|
| DATE OF INCIDENT: | _ TIME: | a.m | p.m. | |
| RESULT OF INCIDENT: For Acc | idents check all th | at apply, for Near Mi | sses ONLY 6 & 7 ma | y be checked |
| 1) FIRE 2) EXPLOSIC | ON 3)∏ EQUIP | MENT DAMAGE | 4) PROPERTY | DAMAGE |
| 5) PRODUCT LOSS 6 | PRODUCTIO | N LOSS 7)∏ EMP | LOYEE ENDANGE | RMENT |
| 8) OTHER | | | | |
| PERSON(S) DIRECTLY INVOLVENAME: | | Name: | | |
| Name: | | Name: | · | |
| EXACT LOCATION WHERE INC | IDENT OCCURREI | | | |
| DESCRIBE FULLY HOW INCIDE | NT OCCURRED: _ | | | |
| | + | | | |
| WHAT UNSAFE ACTS/CONDITION | | | | |
| | | | | |
| RECOMMENDATIONS TO PREV | ENT REOCCURRE | NCE: | | |
| | | | | |
| COMMENTS: | | | | |
| WITNESSES (Print): | | | <u>. </u> | |
| Name: |] | Name: | | · |
| Name: | | Name: | | |
| Prepared by (Print): | | | | |
| Approved by (Print): | | | Initials: | |
| Safety Representative Notified (Nam | e): | | | |

Rev 8.01



Employer's Authorization for Examination or Treatment

| (MUST PRESENT PHOTO ID A | |
|--|--|
| Patient Name: Donald Boggman | SSN: (b) (4) |
| Company Name: CES Envisonmental Se | Date of Birth: |
| Location #/Street Address: 4904 Griggs Rea | d Han Tx Date of Injury: |
| Temporary Staffing Agency: — NA — | 1104 |
| WORK-RELATEDINJURYILLNESS | DOT PHYSICAL |
| Post-Accident Substance Abuse Testing: | Preplacement |
| Drug Screen | Recertification |
| Breath Alcohol | Exit |
| Drug Screen and Breath Alcohol | Audiegram |
| Urine Collection Only | Regulated Drug Screen |
| | Urine Collection Only |
| DOT Regulated | Breath Alcohol |
| Non-regulated | |
| PRE-PLACEMENT EVALUATION | SUBSTANCE ABUSE TESTING |
| Job Title: Driver | Regulated |
| Physical Exam | Non-regulated |
| HPE | Urine Collection Only |
| Regulated Drug Screen | Rapid Test |
| Non-regulated Drug Screen | Pre-placement |
| Urine Collection Only | Reasonable Suspicion |
| Hair Collection | Random |
| Audiogram | Periodic |
| | Post-accident |
| | Follow-up |
| SPECIAL PHYSICAL EXAMINATIONS | Breath Alcohol |
| Asbestos | |
| Respirator | BILLING |
| Hazmat | Employee to pay charges at time of service |
| Baseline | Workers' Compensation |
| Other | Insurance Co: |
| | Policy #: |
| | Phone #: |
| Authorized By: Cololad Ellia | Title: HSE Marraga |
| Phone: 713-176-1460 | Date: 6 - 24 - 09 |
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| (copies of this form available at ww | vw.concentrahealth.com) |



SPECIMEN ID NO.

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| Signature of Collector | 1 191 | Quest Diagnostics C | · · · · · · · · · · · · · · · · · · · | ļ |
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| STEP 5: COMPLETED BY DONOR | | | | |
| I certify that I provided my urine specimen to the collector; that I have a provided on this form and on the label affixed to each specimen bottle | | п bottle used was sealed with | a tamper-evident seal in my presence; a | nd that the information |
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| Signature of Medical Review Officer | (PRINT) Medical Re | view Officer's Name (First, MI, | , Last) | Date (Mo./Day/Yr.) |

HOW DO I USE ADVANCED SEARCH?

The advanced search function provides the ability to search for specific database criteria including: title, date, author, recipient, regulatory citation, statutory citation, RCRA Online Number, RCRA Permit Policy Compendium (RPPC) number, National Technical Information Service (NTIS) number, and EPA Document Number.

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The advanced search also provides the functionality to tailor your specific search even further. You can select whether you want search results to include or exclude documents that are marked as official OSW Policy. Additionaly, you can set your search to bring back only a specific document type

which include "memo/letter," "question and answer," and "publication" types. Finally, if you fill in more than one search field/criteria, you can perform a refined search by setting the dropdown to "All," this search will only find documents that meet all of your specific criteria. By default the search will look for any documents that meet at least one of your search criteria.

HOW CAN I GET ADDITIONAL HELP FINDING DOCUMENTS CONTAINED IN RCRA ONLINE?

If you want more information on the RCRA program, please visit the Office of Solid Waste "Contact Us" web page at www.epa.gov/epaoswer/osw/comments.htm. This page provides, among others, links to EPA's Regional Offices, State environmental offices and the RCRA Frequently Asked Questions (FAQ) database.

WHERE CAN I DIRECT SUGGESTIONS AND PROBLEMS?

Please direct technical problems, such as functionality or the use of RCRA Online, to the RCRA Online administrators using the RCRA Frequently Asked Questions (FAQ) database, available at

> http://waste.custhelp.com/cgi-bin/ waste.cfg/php/enduser/std_alp.php

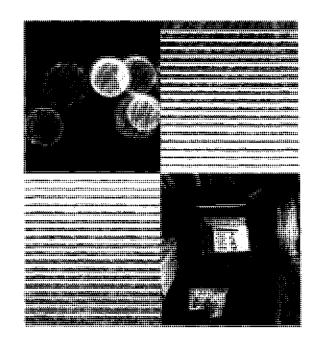
EPA530-F-08-005 February 2008



United States Environmental Protection Agency

RCRA ONLINE

A Quick Reference Guide



WHAT IS RCRA ONLINE?

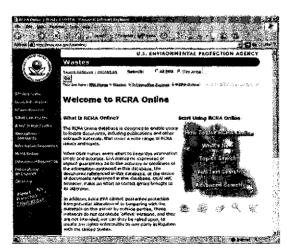
RCRA Online is an electronic database of selected letters, memoranda, questions and answers, publications, and other outreach materials, written by the Environmental Protection Agency's (EPA) Office of Solid Waste (OSW) since 1980. These documents cover the management of non-hazardous, hazardous, and medical waste regulated by the Resource Conservation and Recovery Act (RCRA). Updates occur on a monthly basis.

HOW DO ! ACCESS IT?

RCRA Online can be accessed using a minimum of Netscape Navigator 4.x or Microsoft Internet Explorer 4.x. Simply run the browser and connect to RCRA Online directly by entering the URL:

http://www.epa.gov/rcraonline

From the the Welcome Page, you can navigate to one of the three different search screens to begin your document search. RCRA Online provides users with the capability to view and print the actual text of the documents identified in a search.

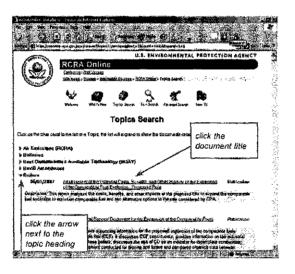


HOW DO I SEARCH TOPICS?

RCRA Online allows users to locate documents though topical, full text, and advanced search functions. Using the topic search function is the simplest way to locate documents in the database.

The topics cover a wide range of RCRA subjects. To search the database by topic, choose the topic search icon on the tool bar.

Click on the blue arrow next to the desired topic. To view detailed information on a particular document, simply click on the document title.



Helpful Hint

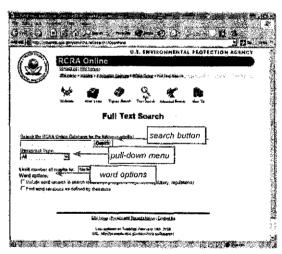
To search for a word using only the first few characters of the word, use the * (asterisk) as a wild card (e.g., if searching for battery or batteries type "batt*").

HOW DO I SEARCH FULLTEXT?

Type the keyword or keywords into the search field, separating each word with a space (e.g., battery lead plate). To search for a string of words in a particular order, or to search for exact phrases, group the words within quotation marks (e.g., "battery lead plate").

You can limit the number of documents in your search by using the pull down menu and choosing the desired number.

The full text search also provides the option to search for word variants (e.g., "battery" will show references to "battery" and "batteries") and for synonyms or related words (e.g., the word "gas" will also show the words "vapor," "fumes," and "helium").



To perform the search, click on the "Search" button adjacent to the keyword field. The database will display a list of all the documents that meet the search parameters. To view detailed information on a particular document, simply click on the document title.



The organic air emission standards for tanks, surface impoundments, and containers became effective on December 6, 1996.

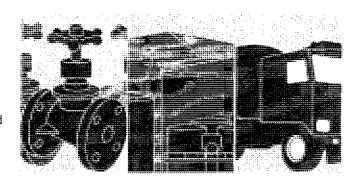
Prior to publication in the Code of Federal Regulations, subpart CC regulations can be found in the Federal Register (FR) at 59 FR 62896, December 6, 1994, as amended at 60 FR 50426, September 29, 1995; 61 FR 4903, February 9, 1996; 61 FR 59932, November 25, 1996; 62 FR 64636, December 8, 1997.

United States Environmental Protection Agency Solid Waste and Emergency Response (5305W) Region 3 Waste and Chemicals Management Division EPA530-F-98-011 July 1998 http://www.epa.gov/osw

RCRA Organic Air Emission Standards for TSDFs and Generators

Purpose

The purpose of this document is to inform you of the requirements of the Resource Conservation and Recovery Act (RCRA) organic air emission standards contained in



40 CFR Parts 264/265, subpart CC. The Environmental Protection Agency (EPA) is responsible for the enforcement of the subpart CC standards until states become authorized to implement the regulations.

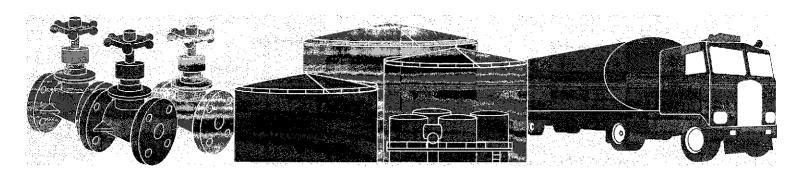
The information contained in this summary document is solely for the convenience of the reader. It is the responsibility of the facility to comply with all regulatory requirements as promulgated. For a complete understanding of all applicable requirements, the facility should refer to the regulations contained in the Code of Federal Regulations (CFR).

Section 3004(n) of RCRA requires the development of standards to control air emissions from hazardous waste treatment, storage, and disposal facilities (TSDFs) as necessary to protect human health and the environment. EPA has promulgated a series of regulations to implement this requirement. These regulations control air emissions from certain process vents and equipment leaks (parts 264 and 265, subparts AA and BB), as well as air emissions from certain tanks, containers, and surface impoundments (subpart CC). The subpart AA and BB standards became effective on December 21, 1990. See page 6 for a detailed discussion of the subpart AA and BB standards. The subpart CC organic emission control standards became effective on December 6, 1996.

When the rules were issued, EPA estimated that organic air emissions from hazardous waste TSDFs exceeded 2 million tons/year. These air emissions can contain toxic organic compounds as well as ozone precursors. Cancer and other adverse health effects may result from exposure to these organic emissions. Subpart CC standards are designed to reduce the level of organic air emissions to approximately 150,000 tons/year.



Recycled/Recyclable
Paper contains at least 20 percent postconsumer fiber.





Applicability

The subpart CC standards of 40 CFR part 264 (Permitted Facilities) and part 265 (Interim Status Facilities) apply to owners and operators of all facilities that treat, store, or dispose of hazardous waste in tanks, surface impoundments, or containers if the waste management units are subject to 40 CFR parts 264/265, subparts I, J, or K, after December 6, 1996. This includes large-quantity hazardous waste generators (≥1,000 kg/month) storing hazardous waste in tanks or containers for less than 90 days.

See 40 CFR 264.1080 or 265.1080 to determine if your waste management units are subject to the subpart CC regulations. See 40 CFR 264.1082 and 265.1083 for a description of hazardous wastes and waste management units that are exempt from the subpart CC standards. Generally, if a hazardous waste has an average volatile organic (VO) concentration less than 500 parts per million by weight (ppmw) at the point of waste origination or if the hazardous waste organic content has been reduced by a treatment process to the extent described in 40 CFR 264.1082 or 265.1083 prior to placement in the waste management unit, the unit is exempt from the air emission controls required under the standards. The procedures to be used for determining average VO concentration and other waste characteristics are specified in 40 CFR 264.1083 and 265.1084.

An owner or operator of an exempt waste management unit is required to maintain records that document the rationale for the exemption.

Effective Dates

The subpart CC standards became effective on December 6, 1996. If the required air emission control equipment was not operational by December 6, 1996, the owner or operator was required to develop an implementation schedule for the equipment installation and startup. The schedule must have been placed in the facility records by December 6, 1996. For most facilities, the final date by which all required air emission equipment must have been installed and operating was December 8, 1997. Waste stabilization tank controls must be installed by June 8, 1998.

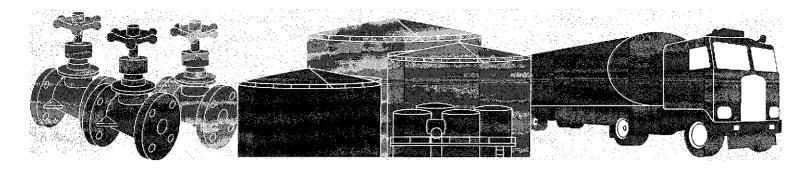
Tanks

Subpart CC standards applicable to tanks containing hazardous wastes are specified in 40 CFR 264.1084 and 265.1085. There are two levels of air emission controls for tanks based on the size of the tank, maximum organic vapor pressure of the waste, and whether the tank is used in a waste stabilization process. The owner or operator is responsible for determining whether Tank Level 1 or Tank Level 2 controls are applicable.

Tank Controls

- If a tank's waste is greater than or equal to 500 ppmw VO, then air emission controls must be used.
- Level of control is determined based on tank capacity, vapor pressure at storage conditions, and waste stabilization. Table 1 provides a matrix for determining the applicable control level for a tank.

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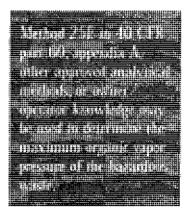


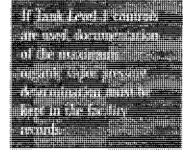
- 3. If a tank qualifies for Level 1 controls, a tight-fitting cover (i.e., fixed roof) can be used and the owner or operator using Level 1 must determine the maximum organic vapor pressure for each hazardous waste placed in the tank as specified by 40 CFR 265.1084(c). Records of the maximum organic vapor pressure determination are required. These records must include the date and time the samples were collected, the analytical method used, and the results.
- 4. If a tank qualifies for Level 2 controls, the following control options are available to the owner/operator:
 - External floating roof (EFR)
 - Internal floating roof (IFR)
 - Vent to control device
 - Pressure tank

Vent to an enclosed combustion device.

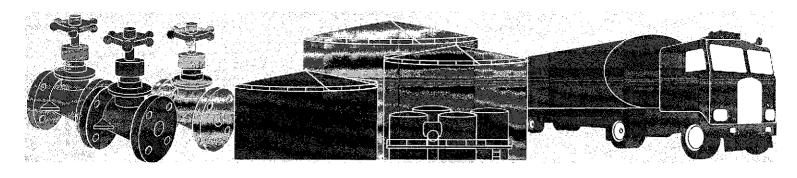
All tanks regulated by the subpart CC standards must be regularly inspected. Inspection procedures and requirements vary by type of tank control used. Records of all inspections, regardless of the control level, must be kept at the facility for a minimum of 3 years after the date of the inspection.

Owners or operators of tanks with internal or external floating roofs using Tank Level 2 controls are required to notify the Regional Administrator before conducting inspections. More detailed recordkeeping and inspection requirements are also required for floating roof tanks and tanks or enclosures that vent to a control device.





| Table 1. Determination of Applicable Level of Control for Tanks Containing Hazardous Waste Subject to the Subpart CC Regulations | | | | |
|--|--|---|-----------------------------------|--|
| Tank Design Capacity | Maximum Organic Vapor Pressure of Hazardous Waste in Tank | Does Waste Stabilization Process Occur in Tank? | Applicable Level of Control | |
| 344 XXX | ≤76.6 kPa //*** (11.1 psi)a * | Yes | Tank Lévél 2 Controls | |
| .≁×₹ 7 5 m³·″_ | | NO PARTIES | Tarik Level T Controls | |
| (20,000 gal)- | >76.6 kPå | A Ves | Slarik Level 2 Controls | |
| and Paradist | TO THE PARTY OF TH | No. of the No. | "Tank Level 2 Controls | |
| ≥75 m ³ | ≤27,6 kPa | Yes | Tank Level 2 Controls | |
| (20,000 gal) and | (4.0 psi) | No | Tank Level 1 Controls | |
| <151 m ³ (40,000 gal) | >27.6 kPa | Yes | Tank Level 2 Controls | |
| | And the state of t | No | Taпk Level 2 Controls | |
| | _≤5.2 kPa | -Mos | Jank Level 2 Controls | |
| ≥151 m³ √ (40,000 gal) ≛ | (0.75 psi) | Western Average | Tank Level 1 Controls | |
| | >5.2 kPa | Yesamir | Tank Level 2 Controls | |
| | Carrier Control of Con | No Service | Tank Level 2 Controls | |



Surface impoundments subject to subject to subject CC control requirements mass base at Pasting membrane cover or a cover remed to a coverol derice.

Transport vehicles, such as tank tracks and tank will cars, any considered to be containers under RURA.

Container Level 1 or 2 controls can be satisfied by property using a DOT container approved for basardors material managem.

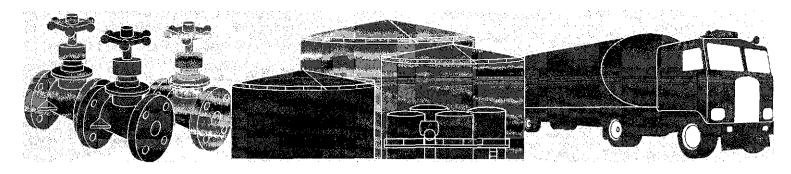
Surface Impoundments

Subpart CC standards applicable to surface impoundments containing hazardous wastes are found in 40 CFR 264.1085 and 265.1086. To control air emissions from a surface impoundment managing a hazardous waste with a VO concentration >500 ppmw, an owner or operator must install and operate either a floating membrane cover or a cover that is vented through a closed-vent system to a control device. The floating membrane cover must meet certain design requirements specified in the rule including a requirement that the cover be made of high-density polyethylene with a thickness no less than 2.5 mm or of an equivalent material. The surface impoundment covers and closure devices are to be visually inspected for defects on or before the date that the unit is subject to the subpart CC standards and at least once a year thereafter. First efforts at repair of any defects detected on the cover or closure devices must be made within 5 days of detection, and repairs must be completed within 45 days of detection. A repair may be delayed more than 45 days only if it requires emptying the surface impoundment or removing it from service and no alternative capacity is available at the facility to accept the hazardous waste normally managed in the unit. Records of all inspections must be kept at the facility for a minimum of 3 years from the date of the inspection.

Containers

Subpart CC standards applicable to containers of hazardous wastes are specified in 40 CFR 264.1086 and 265,1087. There are three levels of air emission controls for containers based on container size, organic contents, and whether the container is used in a waste stabilization process. Table 2 provides a matrix for determining the applicable control level for a container. Containers with a capacity less than 0.1 m³ (26 gallons) are exempted from the rule. Container Level 1 controls require that the hazardous waste be stored in an approved Department of Transportation (DOT) container, a container equipped with a cover and closure devices for each opening, or an open-top container with an organicvapor-suppressing barrier. Container Level 2 controls require that the hazardous waste be stored in an approved DOT container, a container that operates with no detectable organic emissions, or a demonstrated vapor-tight container. Container Level 3 controls require that the hazardous waste be stored in a container that is either vented directly to a control device or is located inside an enclosure that is vented through a closed-vent system to a control device. Design and operating criteria are specified in the rule for the enclosure, closed-vent system, and control device.

If a container is not emptied within 24 hours after it is accepted at the facility, a visual inspection is required on or before the date the container is accepted and at least once a year thereafter. Repairs of defects must be completed within 5 days or the contents of the container must be transferred to a container that is in compliance with the subpart CC standards.



If a non-DOT container larger than 0.46 m³ (119 gallons) is used with Container Level 1 controls, records of the procedure used to determine that the container is not managing hazardous waste "in light material service" must be maintained. The subpart CC standards contain special recordkeeping and inspection requirements for Level 3 containers and their associated closed-vent systems, enclosures, and control devices.

Miscellaneous Units

Certain miscellaneous (subpart X) units may also be subject to subparts AA, BB, and CC if those units managing the hazardous waste are similar to tanks, containers, and surface impoundments. The appropriate air emission controls would be implemented through the issuance or modification of a permit.

Inspection and Monitoring Requirements

Owners or operators are required to inspect and monitor air emission control equipment used to comply with subpart CC in accordance with the applicable requirements specified in §265.1085 through §265.1088. Requirements vary by type of waste management unit and control device used.

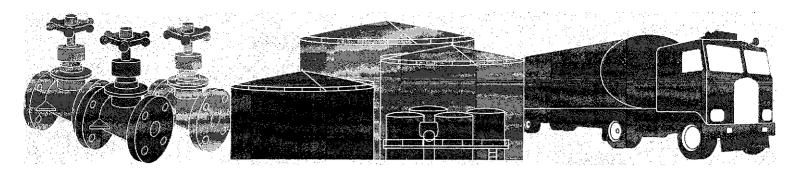
Differences Between Permitted and Interim Status Facilities

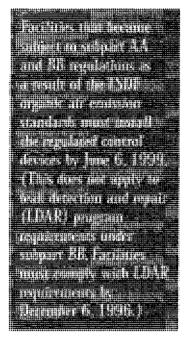
The only difference between the air emission standards for permitted facilities

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Tempertium records moust be content in the sum facility records for at less 3 years from the mountains of impertium.

| Table 2. Determination of Applicable Level of Control for Containers of Hazardous Waste Subject to the Subpart CC Regulations | | | | | |
|---|--|--|---|--|--|
| Container Design Capacity | ls the Container in Light Material Service? | Does Waste Stabilization Process Occur in Container? | Applicable Level of Control | | |
| | NA | VA | Container is Exempt from Air Emission Standards | | |
| ≥0.1 m ³ | Yes | Yes | Container Level 3 Controls | | |
| (26 gal) and | No | No | Container Level 1 Controls | | |
| <0.46 m ³ | No | Yes | Container Level 3 Controls | | |
| (119 gal) | Yes | No | Container Level 1 Controls | | |
| | Yes | ************************************** | Container Level 3 Controls | | |
| ≥0.46 m³ | Non-und | | Container Level 1 Controls | | |
| 3117.481 | No. | Service Control of th | Container Level 3 Controls | | |
| - Nebelia | Yes | No. | Container Level 2 Controls | | |





and interim-status facilities or large-quantity generators (<90-day storage) is the reporting requirement. There are no specific reporting requirements for interim-status facilities or generators. For permitted facilities, the following situations should be reported to the Regional Administrator:

- A waste management unit reported to be exempt from the subpart CC regulations that is no longer complying with the standard that exempted the unit.
- 2. A tank using Tank Level 1 air emission controls that is no longer complying with Level 1 control requirements.
- A control device that has continuously operated in noncompliance with the applicable standards for a period of 24 hours or longer in any 6-month period.

Subpart AA and BB Standards

The TSDF organic air emission standards have made all permitted TSDFs and large-quantity generators subject to the subpart AA and BB regulations as of December 6, 1996. The subpart AA and BB standards of 40 CFR parts 264 and 265 became effective on December 21, 1990, for interim-status TSDFs. Under the subpart CC rule, permitted TSDFs are now required to comply with the subpart AA and BB air emission standards for interim-status facilities until the facility's permit is reviewed or reissued by EPA or the state (when authorized to implement these programs).

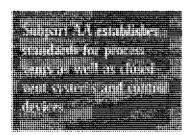
If the required controls (i.e., control devices or process changes) were not installed

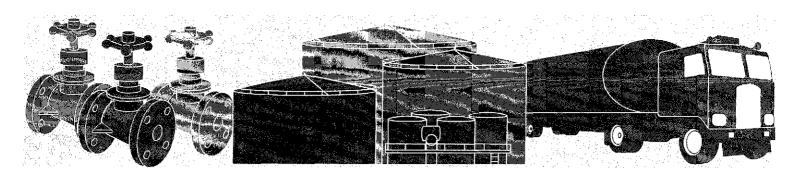
before December 6, 1996, an implementation schedule and an explanation describing why the controls were not installed must be placed in the facility records.

Subpart AA establishes air emission controls for process vents associated with distillation, fractionation, thin-film evaporation, solvent extraction, or air or steam stripping operations that manage hazardous wastes with organic concentrations of at least 10 ppmw. Subpart AA also establishes standards for closed-vent systems and control devices. See 40 CFR 264.1030 through 264.1036 or 265.1030 through 265.1035 for all of the air emission standards for process vents, closed-vent systems, and control devices.

Subpart BB establishes air emission controls for equipment leaks. Subpart BB applies to equipment that contains or contacts hazardous wastes with organic concentrations of at least 10% by weight. If the equipment contacts hazardous waste or hazardous waste residues less than 300 hours per year or if the equipment is in vacuum service, it is excluded from the subpart BB standards. Types of equipment regulated by subpart BB include pumps, compressors, pressure-relief devices, sampling connection systems, valves, open-ended valves or lines, and flanges. (The allowance for an implementation schedule does not apply to the leak detection and repair [LDAR] program for pumps and valves. LDAR must be in place by December 6, 1996.)

Each piece of equipment that is subject to the subpart BB standards must be marked in such a manner that it can be readily distinguished from other pieces of equipment. The equipment must be monitored and inspected regularly. Specific inspection requirements are contained in 40 CFR





264.1052 through 264.1060 or 40 CFR 265.1052 through 265.1060. Most equipment leaks must be repaired within 15 calendar days, although a leaking pressure-relief device must be repaired within 5 calendar days.

Recordkeeping requirements include equipment identification, equipment description and location, methods of compliance monitoring, and equipment LDAR records. See the Code of Federal Regulations for more specific recordkeeping requirements.

Waste Minimization

The hazardous waste generated by a company can cut into that company's profit margin. Not only are there costs to manage, transport, and dispose of waste, valuable resources could be discarded inadvertently and potential liabilities incurred. More and more companies are taking steps to minimize hazardous waste generation in their facilities to reduce the financial burden of the RCRA regulations. EPA may be able to help.

For more information on minimizing hazardous waste, contact the RCRA Hotline at 800-424-9346 or TDD-800-553-7672 or visit the web site at: http://www.epa.gov/osw/minimize

Definitions

Average volatile organic concentration – The mass-weighted average volatile organic concentration of a hazardous waste as determined in accordance with the requirements of §265.1084(a).

Closed-vent system – A system that is not open to the atmosphere and that is composed of piping, connections, and, if necessary, flow-inducing devices that transport gas or vapor from a piece or pieces of equipment to a control device.

Control device – An enclosed combustion device, vapor recovery system, or flare. Any device the primary function of which is the recovery or capture of solvents or other organics for use, reuse, or sale is not a control device.

Enclosure – A structure that surrounds a tank or container, captures organic vapors emitted from the tank or container, and vents the captured vapors through a closed-vent system to a control device.

In light material service – A container that is used to manage a material for which both of the following conditions apply: the vapor pressure of one or more of the organic constituents in the material is greater than 0.3 kilopascals (kPa) at 20 °C and the total concentration of the pure organic constituents having a vapor pressure greater than 0.3 kPa at 20 °C is equal to or greater than 20% by weight.

Maximum organic vapor pressure – The sum of the individual organic constituent partial pressures exerted by the material contained in a tank, at the maximum vapor-pressure-causing conditions (e.g., temperature, agitation, pH effects of combining wastes) reasonably expected to occur in the tank. Maximum organic vapor pressure is determined using the procedures specified in §265.1084(c).

No detectable organic emissions – No escape of organics to the atmosphere as determined using procedures described in §265.1084(d).





Point of waste origination – (1) When the facility owner or operator is the generator of the hazardous waste, the point of waste origination means the point where a solid waste produced by a system, process, or waste management unit is determined to be a hazardous waste as defined in 40 CFR part 261. (2) When the facility owner or operator is not the generator of the hazardous waste, point of waste origination means the point where the owner or operator accepts delivery or takes possession of the hazardous waste.

Point of waste treatment – The point where a hazardous waste to be treated in accordance with \$265.1083(c) (2) exits the treatment process. Any waste determination must be made before the waste is conveyed, handled, or otherwise managed in a manner that allows the waste to volatilize to the atmosphere.

Volatile organic concentration – The fraction by weight of the volatile organic compounds with a Henry's law constant value of at least 0.1 y/x contained in a hazardous waste expressed in terms of ppmw as determined by direct measurement or by knowledge of the waste in accordance with the requirements of \$265,1084.

Waste determination – Performing all applicable procedures in accordance with the requirements of \$265.1084 to determine whether a hazardous waste meets standards specified in subpart CC. For example, determining the volatile organic concentration of a hazardous waste stream.

Waste stabilization process – Any physical or chemical process used to either reduce the mobility of hazardous constituents in a hazardous waste or eliminate free liquids as determined by Test Method 9095 (Paint Filter Liquids Test) in Test Methods for Evaluating Solid Waste, Physical/Chemical Methods, EPA Publication No. SW-846, Third Edition, September 1986, as amended by Update I, November 15, 1992. A waste stabilization process involves mixing the hazardous waste with binders or other materials and curing the resulting hazardous waste and binder mixture. Other synonymous terms used to refer to this process are "waste fixation" or "waste solidification." This does not include the adding of absorbent materials to the surface of a waste, without mixing, agitation, or subsequent curing, to absorb free liquid.

Please content the RCEA Efective at (900) 424–9306 ca TDC) 1800 555–7672 (in the Washington, DC, area can (703) 412–9810) to find our year EPA Regional Permitting and Enforcement compacts.



U.S. Environmental Protection Agency 401 M Street (5305W) Washington, DC 20460

Official Business Penalty for Private Use \$300

Fact Sheet EPA530-F-09-003

EPA Announces Reorganization and Name Change for the Office of Solid Waste (OSW); OSW Becomes the Office of Resource Conservation and Recovery and Streamlines Its Operations

Action

Effective January 18, 2009, the Office of Solid Waste (OSW) is reorganized and has changed its name to the *Office of Resource Conservation and Recovery (ORCR)*. The name change reflects the breadth of the responsibilities/authorities that Congress provided to EPA under the Resource Conservation and Recovery Act (RCRA), the primary authorizing statute. The ORCR has three divisions, which consolidate the operations of the six divisions under the old OSW structure. This reorganization will create a more efficient structure, consistent with current program priorities and resource levels, which will enable EPA to better serve the needs of the public and its key stakeholders over the next 5-10 years. EPA has increased focus on resource conservation and materials management; the emphasis on this important aspect of the RCRA program is expected to continue while maintaining a strong waste management regulatory and implementation program.

This reorganization also:

- consolidates the four major areas of the Resource Conservation Challenge (RCC) under one division:
- combines data collection and data analysis activities thus streamlining operations to better coordinate EPA's efforts to analyze and present the benefits of its program; and
- consolidates waste-to-energy activities in one division and branch.

The three divisions in the new organization are: Materials Recovery and Waste Management Division; Resource Conservation and Sustainability Division; and, Program Implementation and Information Division.

For More Information

For more information, visit: http://www.epa.gov/epawaste/basicinfo.htm



United States
Environmental Protection
Agency

October 2008 EPA530-F-08-006 www.epa.gov/waste

Modification to the Definition of Solid Waste Aims To Increase Recycling

EPA is streamlining its regulation of hazardous secondary materials to encourage beneficial recycling via reclamation and help conserve resources. By doing so, recycling these materials will not only be safe, but also less costly and more efficient.

Action

In October 2003, EPA proposed a regulatory exclusion from the definition of solid waste which would streamline requirements for the recycling of hazardous secondary materials. After evaluating public comments and conducting independent analyses, the Agency published a supplemental proposal in March 2007. This rule finalizes the March 2007 supplemental proposal by establishing streamlined requirements for the following:

- Materials that are generated and legitimately reclaimed under the control of the generator (i.e., generated and reclaimed on-site, by the same company, or under "tolling" agreements);
- Materials that are generated and transferred to another company for legitimate reclamation under specific conditions; and,
- Materials that EPA or an authorized state determines to be non-wastes through a case-by-case petition process.

The rule also contains a provision to determine which recycling activities are legitimate under the new exclusions and non-waste determinations. This provision ensures that only authentic recycling, and not treatment or disposal under the guise of recycling, receives the benefits of these streamlined regulations. In order to be legitimately recycled under these exclusions, the hazardous secondary material (1) must provide a useful contribution to the recycling process; and (2) the recycling must make a valuable new intermediate or final product. Two additional factors must also be taken into account: (1) whether the recycled material is managed as a valuable product; and (2) whether the recycled product contains toxic constituents at significantly greater levels than a non-recycled product made from virgin materials.

These exclusions are not available for materials that are: (1) considered inherently waste-like; (2) used in a manner constituting disposal; or (3) burned for energy recovery.

The restrictions for the exclusions in this final rule are substantially similar to those contained in the supplemental proposal published on March 26, 2007 (72 FR 14172) with certain modifications regarding:

- · Reporting and recordkeeping;
- Reasonable efforts required of generators to ensure that their hazardous secondary materials are safely and legitimately recycled;
- Intermediate facilities storing hazardous secondary materials for more than 10 days are eligible under the transfer-based exclusion; and
- Tailoring the financial assurance requirements to intermediate facilities and reclaimers of hazardous secondary materials.

The Agency estimates that about 5,600 facilities handling approximately 1.5 million tons of hazardous secondary materials annually may be affected by this proposed rule. The activities most affected are metals and solvent recycling. This action is expected to result in cost savings of approximately \$95 million per year for all affected industry sectors.

For More Information

More information about the Definition of Solid Waste: http://www.epa.gov/epawaste/hazard/dsw/index.htm. To find out more detailed information or to ask a question, please go to http://waste.custhelp.com and click on Find an Answer or Ask a Question.

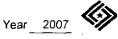
CES Environmental Services, Inc.

4904 Griggs Road Houston, TX 77021 713-676-1460 Tel 713-676-1676 Fax

OSHA 300 SAFETY INFORMATION

| | | 2005 | 2006 | 2007 |
|---|---|---------|---------|---------|
| A | OSHA Recordable incident Rate | 4.14 | 2.90 | 0.67 |
| В | Lost Time Incident Rate | 0 | 0.97 | 0 |
| C | Number of Recordable Injury Cases | 3 | 3 | 1 |
| D | Number of Lost Time Incidents/Illnesses | 3 | 3 | 0 |
| E | Days away from work | 0 | 18 | 0 |
| F | Number of Fatalities | 1 | 0 | 0 |
| G | Total Employee Hours Worked | 145,040 | 206,868 | 297,255 |
| Н | Experience Modification Rate | 0.81 | 0.70 | 0.92 |

OSHA's Form 300A Summary of Work-Related Injuries and Illnesses



U.S. Department of Labo
Occupational Safety and Health Administration

Form approved OMB no. 1218-017

All establishments covered by Part 1904 must complete this Summary page, even if no injuries or illnesses occurred during the year. Remember to review the Log to verify that the entries are complete

Using the Log, count the individual entries you made for each category. Then write the totals below, making sure you've added the entries from every page of the log. If you had no cases write "0,"

Employees former employees, and their representatives have the right to review the OSHA Form 300 in its entirety. They also have limited access to the OSHA Form 301 or its equivalent. See 29 CFR 1904.35, in OSHA's Recordkeeping rule, for further details on the access provisions for these forms.

| Number of Cases | : . | er en en en en en en en en en en en en en | |
|---|--|--|--|
| Total number of deaths | Total number of cases with days away from work | Total number of cases with job transfer or restriction | Total number of other recordable cases |
| 0 | | 1 | |
| (G) | (H) | (1) | (J) |
| Number of Days | | en de la composition de la composition de la composition de la composition de la composition de la composition La composition de la composition de la composition de la composition de la composition de la composition de la | |
| Total number of days of job transfer or restriction | | Total number of days away from work | |
| 10 | | G | |
| (K) | - | (L) | |
| Injury and Illness T | ypes | | |
| Total number of (M) | | | |
| (1) Injury | 11 | (4) Poisoning | 0 |
| (2) Skin Disorder | 0 | (5) All other illnesses | Ó |
| (3) Respiratory | | | |
| Condition | 0 | | |

Post this Summary page from February 1 to April 30 of the year following the year covered by the form

Public reporting burden for this collection of information is estimated to average 50 minutes per response, including time to review the instruction, search and gather the data needed, and complete and review the collection of information. Persons are not required to respond to the collection of information unless it displays a currently valid OMB control number. If you have any comments about these estimates or any aspects of this detacollection, contract. US Department of Labor. OSHA Office of Statistics. Room N-3544, 200 Constitution Ave. NW. Washington. OC 20210. On not send the completed forms to this office.

Establishment information Your establishment name CES Environmental Services Inc. Street 4904 Griggs Road Industry description (e.g., Manufacture of motor truck trailers) Environmental services, tank cleaning, trucking Standard Industrial Classification (SIC), if known (e.g., SIC 3715) 1 5 4 2 Employment information Annual average number of employees 98 Total hours worked by all employees last year 297,255 Sign here Knowingly falsifying this document may result in a fine. I certify that I have examined this document and that to the best of my knowledge the entries are true, accurate, and complete. Company executive 713-676-1460 1/2/2008 Phone Date

OSHA's Form 300 Log of Work-Related Injuries and Illnesses

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

Year 2007

U.S. Department of Labor
Occupational Safety and Health Administration

Form approved QMB no. 1218-0176

You must record information about every work-related injury or litness that involves loss of consciousness, restricted work activity or job transfer, days away from work, or medical treatment beyond first aid. You must also record significant work-related injuries and illnesses that are diagnosed by a physician or licensed health care professional. You must also record work-related injuries and illnesses that meet any of the specific recording order in listed in 29 CFR 1904.8 through 1904.12. Feel free to use two lines for a single case if you need to. You must complete an injury and illness incident report (OSHA Form 301) or equivatent form for each injury or liness recorded on this form. If you're not sure whether a case is recordable, call your local OSHA office for help.

Establishment name CES Environmental Services, Inc.

State Texas Houston Classify the case Identify the person Describe the case Enter the number of days (A) (B) the injured or ill worker Check the "injury" column or choose Using these categories, check ONLY the most Where the event occurred (e.g. Job Title (e.g. Describe injury or illness, parts of body affected, and Case Employee's Name Date of one type of illness: serious result for each case: was: object/substance that directly injured or made person ill-Welder) injury or Loading dock north end) (e.g. Second degree burns on right forearm from onset of On job Away from acetylene torch) ifiness Days away Death Remained at work transfer or work (mo./day) from work restriction (days) Other record-(days) Job transfer able cases or restriction (L) (3) 9/13/2007 17225 El Camino Rd Cut finger Percy Foster rechnician Page totals Be sure to transfer these totals to the Summary page (Form 300A) before you post it. Disorder Public reporting burden for this collection of information is estimated to average 14 minutes per response, including time to

Public reporting burden for this collection of information is estimated to average 14 minutes per response, including time to review the instruction, search and gather the data needed, and complete and review the collection of information. Persons are not required to respond to the collection of information unless it displays a currently valid CMB control number. If you have any comments about these estimates or any aspects of this data collection, contact. US Department of Labor, OSHA Office of Statistics, Room N-3544, 200 Constitution Ave, NW. Washington, DC 20210. Do not send the completed forms to this office.

Page 1 of 1

) (2) (3) (4)

OSHA's Form 301 Injuries and Illnesses Incident Report

Information about the employee

1) Full Name Foster Percy

2) Street 5126 Ditmas

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

Information about the case

10) Case number from the Log

11) Date of injury or illness

U.S. Department of Labor

Occupational Safety and Health Administration

2 (Transfer the case number from the Log after you record the case.)

Form approved OMB no. 1218-0176

This Injury and Illness Incident Report is one of the first forms you must fill out when a recordable work-related injury or illness has occurred. Together with the Log of Work-Related injuries and Illnesses and the accompanying Summary, these forms help the employer and OSHA develop a picture of the extent and severity of work-related incidents.

| the accompanying Summary, these forms help the | City Houston State TX Zip 77021 | 12) | Time employee began work 06:00:00 AM AM/PM | | | | |
|--|--|-----|---|--|--|--|--|
| employer and OSHA develop a picture of the extent and severity of work-related incidents. | 3) Date of birth | 13) | Time of event 9:00 AM AM/PM Check if time cannot be determined | | | | |
| Within 7 calendar days after you receive information that a recordable work-related injury or illness has occurred, you must fill out this form or an equivalent. Some state workers' compensation, insurance, or other reports may be acceptable substitutes. To be considered an equivalent form, any substitute must contain all the information asked for on this form. According to Public Law 91-596 and 29 CFR | 4) Date hired B/14/2007 5) X Male Female Information about the physician or other health care professional 6) Name of physician or other health care professional | 14) | What was the employee doing just before the incident occurred? Describe the activity, as well as the tools, equipment or material the employee was using. Be specific. Examples: "climbing a ladder while carrying roofing materials"; "epraying chlorine from hand sprayer"; "daily computer key-entry." Assembling flex hose What happened? Tell us how the injury occurred. Examples: "When ladder slipped on wet floor, work fell 20 feet": "Worker was spayed with chlorine when gasket broke during replacement": "Worker | | | | |
| 1904, OSHA's recordkeeping rule, you must keep this form on file for 5 years following the year to which it pertains If you need additional copies of this form, you may photocopy and use as many as you need. | 7) If treatment was given eway from the worksite, where was it given? | | developed soreness in wrist over time." Accidental cut using a box cutter | | | | |
| | Facility Concentra Street 10909 I-10 East Frwy City Houston State TX Zip 77029 | 16) | What was the injury or illness? Tell us the part of the body that was affected and how it was affected be more specific than "hunt", "pain", or "sore." Examples: "strained back"; "chemical burn, hand"; "carp tunnel syndrome." Cut linger | | | | |
| Completed by <u>Prabhakar R. Thangudu</u> Title <u>HSE Manager</u> | 8) Was employee treated in an emergency room? Yes No 9) Was employee hospitalized overnight as an in-patient? | 17) | What object or substance directly harmed the employee? Examples: "concrete floor"; "chlorine"; "redial arm saw." If this question does not apply to the incident, leave it blank. Box cutter | | | | |
| Phone <u>713-676-1460</u> Date <u>9/14/2007</u> | `∏Yes X`No | 18) | if the employee died, when did death occur? Date of death | | | | |

Public reporting burden for this collection of information is estimated to average 22 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Persons are not required to respond to the collection of information unless it displays a current valid OMB control number. If you have any comments about this estimate or any other aspects of this data collection, including suggestions for reducing this burden, contact: US Department of Labor, OSHA Office of Statistics, Room N-3544, 200 Constitution Ave, NW, Washington, DC 20210. Do not send the completed forms to this office.

O-6 and drawer how 1200 " Safet, "
ble Savoy, Anthony # 4-14-09

EPAHO042001701



Claim Number: 99K

99K000056689204

Notification Date: 06/02/2009

EMPLOYER'S FIRST REPORT OF INJURY

INJURED EMPLOYEE **BUSINESS/EMPLOYER** Name: CES ENVIRONMENTAL SERVICES I Name: ANTHONY SAVOY XXX-XX<mark>(b)</mark> SSN: Address: Mailing 4904 GRIGGS RD HOUSTON TX 77021-3208 Address: **Phone:** (713)676-1460 **Ext:** Fax: (713)676-1676 County: Policy Number: 0001086044 Physical Address: FEIN: 760592985 Location ID: County: 4 **EMPLOYMENT** Home Phone: Occupation: WAREHOUSE SUPERVISOR/OPERATION Date of Birth: Hire Date: 00/00/0000 State: TX Marital Status: Not Married Partner/Officer/Owner: Gender: Dependents: 00 Male Date Lost Time Began: 00/00/0000 Language: Return to Work Date: English 00/00/0000 Last Paycheck was: MEDICAL PROVIDER Wage: Frequency: Name: Tax ID: Hours/Week: Days/Week: Period Start: 00/00/0000 Period End: 00/00/0000 Address: Supervisor Name: BRYAN WEATHERS Phone: Ext: Phone: Fax: PREPARER OF REPORT **ATTORNEY** Name: ANTHONY SAVOY Represented by Attorney: Yes **Phone:** (713)269-0544 **Ext:** Fax: Name: Email: Phone: INJURY_INFORMATION Date of Injury: 04/14/2009 Time: 13:00 Address Where Injury Occurred: **Date Reported:** 00/00/0000 Nature of Injury: MENTAL STRESS County: JEFFERSON Witnesses: Cause of Injury: MISC. CAUSES-OTHER Name: MISCELLANEOUS, NOC Phone: Name: UNKNOWN/ NOT Part of Body: Phone: REPORTED

How and Why the Injury/Illness Occurred

No

Fatality:

PSYCHOLOGICAL. WAS IN LAB DOING WORK WHEN ANOTHER EMPLOYEE SCREAMED THAT BRENT FELL OUT OF CHAIR. HIM AND OTHER EMPLOYEES RAN TO SEE WHAT HAPPENED I SAW BRENT LYING ON GROUND FACE UP BLOOD WAS COMING OUT OF HIS NOSE, AFTER SEEING THAT HE DID REACT AND IT BECAME TO OVERWHELMING AND WALKED AWAY PER DWC-41.

Name:

Phone:



06/04/2009

C E S ENVIRONMENTAL SERVICES I 4904 GRIGGS RD HOUSTON TX 77021-3208

Notification Confirming Receipt of Claim

Date of Injury:

04/14/2009

Injured Worker:

SAVOY. ANTHONS

Claim Number:

b) (4)

Policy Number: 0001086044

Attached is a copy of the information another party reported to Texas Mutual Insurance Company which was used to establish this claim. You may submit additional claim information to Texas Mutual Insurance Company. If you have questions regarding this report of injury please contact us at (800) 859-5995.

If your policy includes our workers' compensation health care network option you are required by law to obtain a second Employee Acknowledgement of Workers' Compensation Network Form signed by the injured worker. Please submit a copy of the signed, second acknowledgement form to Texas Mutual Insurance Company. You can find a copy of the form online at www.texasmutual.com/hcn.shtm

Below please find information that will help you through the claim process:

To submit additional claim information:

To locate a treating doctor:

Mail to: P. O. Box 12029 Austin, Texas 78711-2029

Fax to: (512) 224-3889

www.texasmutual.com/workers/iwADL.shtm

To contact the handling adjuster:

Call: (800) 859-5995

Monday - Friday; 8:00 a.m. - 5:30 p.m.

To obtain a copy of the Employer and Employee Rights and Responsibilities in the

Workers' Compensation System:

www.texasmutual.com/employers/erRights.shtm

To locate a pharmacy, or for pharmacy questions, contact Scripnet:

Call: (888) 880-8562 www.scripnet.com To obtain a copy of the Employer and Employee Rights and Responsibilities for the workers' comp health care network: www.texasmutual.com/hcn/hcn.sbtm

Additional Texas Mutual® online services at www.texasmutual.com, available 6 a.m. - 9 p.m., include:

- o Obtain logon id, or for immediate logon id, call (800) 859-5995, M-F, 8:00 a.m. 5:30 p.m.
- o Submit first report of injury in the Employers section
- o Submit wage statement when reviewing loss runs and claim details
- o Obtain specific claim summary information

C E S ENVIRONMENTAL SERVICES I 4904 GRIGGS RD IJOUSTON TX 77021-3208

Texas Mutual Insurance Company has redesigned the First Report of Injury (eFROI) section of texasmutual.com. More than 55% of all new reports of injury are submitted through the Texas Mutual Online (TMO) application. The redesign makes the first report of injury services more intuitive and easier for policyholders to use.

Here is an overview of the new features:

- Policyholders will now have the ability to login. By logging in, policy information will pre-fill.
- Customers who login will also have the ability to create profiles with information they always want to pre-fill in a first report of injury (such as supervisor or medical provider information).
- A copy function has been added to automatically populate information that may be the same (such as preparer, contact or address information).
- Certain fields have default values. For example, the state field defaults to Texas for all address fields.
- Search functions have been added to make it easier to find the part of body or nature of injury, when reporting a claim.

To use the enhanced online claim reporting tool:

- Go to texasmutual.com
- Click on Report an Injury in the Employer section
- Login with your username and password for policy information to pre-fill, or you have the option to skip login.

To see the redesign, a video is available at the login page. If you are not registered to use Texas Mutual online services, complete the online application at texasmutual.com, or call the Information Services Center at (800) 859-5995.

Send to workers' compensation carrier:

Texas Mutual 713-316-2191

(Name and fax number of carrier)



| CLAIM# | 99K000056689204 |
|---------|-----------------|
| CARRIER | 'S CLAIM # |

| \checkmark | Initial | □ Amended |
|--------------|---------|-----------|
|--------------|---------|-----------|

EMPLOYER'S WAGE STATEMENT

The Texas Workers' Compensation Act and Workers' Compensation rules require an employer to provide an Employer's Wage Statement to its workers' compensation insurance carrier (carrier) and the claimant or the claimant's representative, if any. The purpose of the form is to provide the employee's wage information to the carrier for calculating the employee's Average Weekly Wage (AWW) to establish benefits due to the employee or a beneficiary.

The AWW is based on the wages the employee earned in the 13 weeks immediately preceding the date of injury (or the wage a similar employee earned if the employee did not work the full 13-week period). "Wages" include all forms of remuneration payable to an employee for personal services, including fringe benefits. To simplify filing, employers may file wages in a monthly, biweekly, or weekly manner as discussed below.

NOTE - An employer who fails without good cause to timely file a complete wage statement as required by the Texas Workers' Compensation Act, Texas Labor Code, Section 408.063(c) and Worker's Compensation Rule 120.4 may be assessed an administrative penalty not to exceed \$500.00 for an initial offense and not to exceed \$10,000.00 for a repeated administrative violation.

The employer shall timely file a complete wage statement in the form and manner prescribed by the Division.

- (1) The wage statement shall be filed ("filed" means received) with the carrier, the claimant, and the claimant's representative (if any) within 30 days of the earliest of:
 - (A) the employee's eighth day of disability;
 - (B) the date the employer is notified that the employee is entitled to income benefits:
 - (C) the date of the employee's death as a result of a compensable injury.
- (2) The wage statement shall also be filed with the Division within seven days of receiving a request from the Division (Only When Requested).
- (3) A subsequent wage statement shall be filed with the carrier, employee, and the employee's representative (if any) within seven days if any information contained on the previous wage statement changes (such as if the employer discontinues providing a nonpecuniary wage that was initially continued after the date of injury).

All applicable DWC rules can be found at www.tdi.state.tx.us

| EMPLOYEE AND EMPLOYER INFORMATION | |
|--|--|
| Employee's Name (Last, First, M.I.): | Employer's Business Name: |
| Savoy, Anthony | CES Environmental Services, In |
| Employee's Mailing Address (Street or P.O. Box): | Employer's Mailing Address (Street or P.O. Box): |
| (b) (4) | 4904 Griggs Rd |
| (b) (4) | City: State: ZIP Code: |
| | Houston TX 77021 |
| Social Security Number (last four digits): | Federal Tax I.D. Number: |
| (D) (4) | 76-0592985 |
| Date of Injury: | Name and Phone # of Person Providing Wage Information: |
| 4/14/09 | Prabhakar Thangudu |
| ☐ As of today's date, the employee is not back at work. OR☐ The employee returned to work on and is working: | LUEDERY CERTIFY THAT this was the sent in a sent to the sent to th |
| <u> </u> | I HEREBY CERTIFY THAT this wage statement is complete, accurate, and complies with the Texas Workers' Compensation Act and applicable rules, |
| ☑ without restriction. OR | and the listed wages include all pecuniary and nonpecuniary wages paid for |
| with restrictions and is earning wages of \$ per week/month (circle one). | (earned in) the 13 weeks prior to the date of injury (as described on page 2) and ! understand that making a misrepresentation about a workers' |
| NOTE - Rule 120.3 requires the employer file the Supplemental Report of | compensation claim is a crime that can result in fines and/or imprisonment. |
| Injury (DWC FORM-6) to report changes in Work Status and Post-Injury | 211 057- 1 1-15 |
| Earnings. | Signature: Lakh VI Land Date: 6-15-09 |
| EMPLOYMENT STATUS AT TIME OF INJURY (Check A | All That Apply) |
| ☑ Full-time: employee who regularly works at ☐ Part-time: Regular | Course of Conduct: Minor: employee less than 18 years of age |

- ☑ Full-time: employee who regularly works at least 30 hours per week and whose schedule is comparable to other employees of the company and/or other employees in the same business or vicinity who are considered full-time.
- ☐ Seasonal: employee who as regular course of conduct engages in seasonal or cyclical employment that may or may not be agricultural in nature and that does not continue throughout the year.
- ☐ Part-time: Regular Course of Conduct: employee whose work history for the 12-month period preceding the injury shows the person only worked part-time during that period.
- ☐ Part-time: Not Regular Course of Conduct: employee whose work history for the 12-month period preceding the injury shows part-time and full time work during that period.
- ☐ Apprentice: employee who is learning a skilled trade or art by practical experience under the direction of a skilled crafts person or artisan.
- Minor: employee less than 18 years of age and not emancipated by marriage or judicial action who is also an apprentice, trainee or student.
- Student: employee enrolled in a course of study in high school, college or other institute of higher education or technical training.
- ☐ Trainee: employee undergoing systematic instruction and practice in some art, trade or profession with a view towards proficiency in it.

SAME OR SIMILAR EMPLOYEE?

The wage information on this form is for:

 $\hfill \Box$ The Injured Employee OR $\hfill \Box$ A Similar Employee (NOTE - If requested by the Division, the employer shall identify the similar employee whose wages were provided.)

If the employee was not employed for 13 continuous weeks before the date of injury, report the wages of an employee who has training, experience, skills & wages comparable to the injured employee AND who performs services/tasks comparable in nature and in number of hours. If no similar employee exists, report the limited available wages earned by the injured employee prior to the injury.

NOTE TO INJURED EMPLOYEE – If you were injured on or after 7/1/02, and had employment with more than one employer on the date of injury, you can provide your insurance carrier with wage information from your other employment for the carrier to include in your AWW and this may affect your benefits. Contact your carrier for additional information or call the Division at (800) 252-7031. You can also read rule 122.5 at www.tdi.state.tx.us.

DIVISION OF WORKERS' COMPENSATION

| いいんへき い | IFORMATIO | M M(S) | CTIONS |
|---------|-----------|----------|--------|
| 'A' ^ | | | |
| | | | |

Savoy, Anthony

Social Security # 7608

Nonpecuniary Wages include all wages paid to the employee in a form other than money. These include, but are not limited to, the

Date of Injury: 4/14/09

- The employer shall report all wages earned in the 13 weeks immediately preceding the date of injury. If the employee is paid on a monthly or semi-monthly basis, the employer may provide wages for the 3 months preceding the date of injury. Monthly wages may also be converted to weekly wages by dividing the gross monthly amount by 4.34821. If the employee is paid on a biweekly basis, the employer may provide the wages for the 14 weeks preceding the date of injury. When setting the periods to report, the employer may adjust the reporting period backward slightly (up to six days) to line up the reporting timeframes with the employer's natural pay cycle. However, the employer shall not report wages earned on or after the date of injury.
- If reporting weekly earnings, use all 13 Period Columns below. If reporting 3 months of earnings, either convert the wages to weekly earnings or use the first 3 Period Columns. In all cases, indicate the dates that each period covers.

| PECUNIARY WAGE I | NFORM | ATION | | hourly, we commission commission use of the | ekly, biwee ons. Earnin ons) need to | kly, monthly gs are repo be prorated equipment | t, etc. wage: orted in the I. Pecuniary or for paying | s; salary; tip periods the wages don g helpers or | os/gratuities; y are earne 't include pa to reimburs | piecework of d, NOT who yments mad e for travel o | compensation they are le by an empersor of the | on; monetar paid and s ployer to rei Consider as | y allowance ome (such a mburse the e earnings am | re not limited to: s; bonuses; and as bonuses and employee for the nounts from paid not used. |
|---|---------|-------|-------|--|--|---|--|--|---|--|--|---|---|---|
| PERIOD # (Week #, Month #, or Bi-Week #) | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | |
| FROM DATE: | 1/18 | 1/25 | 2/01 | 2/08 | 2/14 | 2/22 | 3/01 | 3/08 | 3/15 | 3/22 | 3/29 | 4/05 | 4/12 | |
| TO DATE: | 1/24 | 1/31 | 2/07 | 2/14 | 2/21 | 2/28 | 3/07 | 3/14 | 3/21 | 3/28 | 4/04 | 4/11 | 4/18 | TOTALS |
| # HOURS WORKED: | 49.05 | 46.08 | 51.11 | 45.15 | 52.03 | 43.18 | 49.18 | 52.16 | 50.28 | 55.35 | 53.32 | 24.18 | 41.18 | 612.25 |
| GROSS WAGES EARNED: | (b) (4) | | | | | | | | | | | | | |

| Nonpecuniary Wage Type | Provide | Employer Provided Prior To Injury? benefits listed below but do not include monetary allowances or stipends paid to allow the employe benefits listed below but do not include monetary allowances or stipends paid to allow the employe benefits listed below but do not include monetary allowances or stipends paid to allow the employe benefits listed below but do not include monetary allowances or stipends paid to allow the employe Specify Value Or Amount Earned in Each Reported Period For Each Benefit Provided Prior To Injury (Use the same periods as used above) | | | | | | | | | Will Employer Continue To Provide? | | Date Benefit Suspended (if suspended) | | | | | |
|---------------------------|---------|---|---|---|---|---|---|---|---|---|--|----|---|----|----|-----|----|---|
| l | YES | NO | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | YES | NO | 1 |
| Health Insurance | | | | | | | | | | | | | | | | | | |
| Laundry/ Cleaning | | | | | | | | | | | | | | | | | | |
| Clothing/ Uniforms | | | | | | | | | | | | | | | | | | |
| Lodging/ Housing/ | | | | | | | | | | | | | | | | | | |
| Food/ Meals | | | | | | | | | | | | | | | | | | |
| Vehicle/ Fuel | | | | | | | | | | | | | | | | | | |
| Other | | | | | | | | | | | | | | | | | | |





Claim & Information Services
P.O. Box 12029
Austin, TX 78711-2029
1-800-859-5995 (512) 224-3800
Fax (512) 224-3889

June 5, 2009

C E S ENVIRONMENTAL SERVICES 4904 GRIGGS RD HOUSTON, TX 77021-3208

Re: Claim #:

Employee: ANTHONY SAVOY
Soc. Sec.:

Employer: CESENVIRONMENTAL SERVI

Date of Injury: 04/14/2009

Dear C E S ENVIRONMENTAL SERVICES,

I represent Texas Mutual Insurance Company for the above referenced workers' compensation claim.

I have attempted to contact your office and was unable to reach you. Please contact me at your carliest convenience to discuss this claim. I can be reached at (800) 859-5995 ext. 4716. Please disregard this notification if I have spoken with you prior to your receiving this letter.

Thank you for your kind attention to this matter.

Sincerely,

Patricia Cummings
CAT WORKERS' COMP SPEC II



Claim & Information Services P.O. Box 12029 Austin, TX 78711-2029

1-800-859-5995 (512) 224-3800

(512) 224-3889

June 5, 2009

C E S ENVIRONMENTAL SERVICES 4904 GRIGGS RD HOUSTON, TX 77021-3208

Re:

Claim #: Employee:

Soc. Sec.: Employer:

C E S ENVIRONMENTAL SERVI

ANTHONY SAVOY

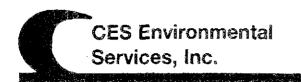
Date of Injury: 04/14/2009 DWC#: PENDING

In accordance with the Division of Workers Compensation Rules, we are requesting that you submit the information indicated below. The DWC3 and DWC6 forms are available for printing from our website, www.texasmutual.com, under services, or from the division's website, www.tdi.state.tx.us. For your convenience, a DWC3 is now available for you to complete and submit on-line. It is located on our website, www.texasmutual.com under the Employers - Loss Run & Claims Detail Section. If you need assistance with filing the DWC3 on-line please contact me. If you do not have access to the Internet, we will be happy to send you a blank form.

| ⊠ on | DWC3 EMPLOYER'S WAGE STATEMENT (Rule 128.2) - Please fax or email attachment or use the on-line version (www.texasmutual.com). |
|----------|--|
| OR ⊠ | DWC3SD EMPLOYER'S WAGE STATEMENT FOR SCHOOL DISTRICTS (Rule 128.7) |
| | DWC6 EMPLOYER'S SUPPLEMENTAL REPORT OF INJURY OR ILLNESS (Rule 120.3) - Please fax or email attachment. The following time frames apply. |
| | Within 10 days after: |
| | The end of each pay period in which the employee's earnings have changed as a result of the injury, OR The employee resigns or is terminated. |
| | Within 3 days after: |
| | The employee begins to lose time from work as a result of the injury, OR The employee returns to work, OR |
| | • The employee, after returning to work experiences an additional days(s) of disability as a result of the injury. |
| | provide the required information is an administrative violation and may result in the assessment of a penalty from the Division of Compensation. |
| AND | |
| | EMPLOYEE ACKNOWLEDGEMENT OF WORKERS' COMPENSATION NETWORK FORM (This form(s) shall be completed, signed and submitted). Please fax or send attachment via email as soon as possible. |
| | COPY OF THE POST-ACCIDENT DRUG SCREEN RESULTS |
| Thank vo | by for your prompt attention to this matter. If you have any questions, please call me at 1-800-859-5995 ext. 4716. |

Patricia Cummings CAT WORKERS' COMP SPEC II

Sincerely,



4904 Griggs Road Houston, TX 77021 Phone: (713) 676-1460 Fax: (713) 676-1676

Fax

Memby Tran #511 6-15-09

To:

Tx mutual

From:

Prabhakar R. Thangudu

(b) (4)

Email: pthangudu@cesenvironmental.com

Fax:

512-724-3889 Pages:

Phone:

Date:

6-15-09

Savoy Anthony

99 K 000056689204





NOTICE OF DENIAL OF COMPENSABILITY/LIABILITY AND REFUSAL TO PAY BENEFITS

DATE:

06/17/2009

TO:

SAVOY, ANTHONY 4460 GOLIAD ST

BEAUMONT TX 77705-4505

RE:

Date of Injury:

NO PHYSICAL INJURY Nature of Injury: Part of Body Injured: NO PHYSICAL INJURY

Employee SSN:

DWC #:

Carrier Name:

Texas Mutual Insurance Company

04/14/2009

09260379

Carrier Claim Number:

Employer:

C E S ENVIRONMENTAL SERVI

4904 GRIGGS RD

HOUSTON TX 77021-3208

On 06/02/2009 we received notice that you reported an on the job injury. We are denying your claim for workers' compensation benefits. Workers compensation benefits, including medical benefits, are not being paid because:

Texas Mutual Insurance Company denies this claim in its entirety. Carrier does not dispute that an incident occurred on 04/14/09 involving a fellow employee's death while at work. However, the Carrier disputes that Mr. Savoy sustained an injury in the course and scope of employment, either as a physical injury or mental trauma. Further, the fellow employee appears to have died from a heart attack and not from any traumatic

If you do not agree with the denial and refusal to pay benefits, please contact me:

Adjuster's Name:

Toll Free Telephone #: Fax #/E-mail Address:

PATRICIA CUMMINGS (800) 859-5995

(512) 224-3889

If we are unable to resolve the issue to your satisfaction, you may contact the Texas Department of Insurance, Division of Workers' Compensation for further assistance. You have the right to request a Benefit Review Conference, You can contact the Division office handling your claim at 1-800-252-7031.

If you would like to receive notices such as this by facsimile or e-mail, please contact me and provide your facsimile number or e-mail address.

Please note that making a false or fraudulent workers' compensation claim is a crime that may result in fines and/or imprisonment.

CC TDVDWC MAIL DELIVERY SAVOY, ANTHONY C E S ENVIRONMENTAL SERVI RUBEN RENDON



C E S ENVIRONMENTAL SERVI 4904 GRIGGS RD HOUSTON TX 77021-3208

Brient Sittig - First Report of Injury 4-14-2009



C E S ENVIRONMENTAL SERVICES I 4904 GRIGGS RD HOUSTON TX 77021-3208

Texas Mutual Insurance Company has redesigned the First Report of Injury (eFROI) section of texasmutual.com. More than 55% of all new reports of injury are submitted through the Texas Mutual Online (TMO) application. The redesign makes the first report of injury services more intuitive and easier for policyholders to use.

Here is an overview of the new features:

- Policyholders will now have the ability to login. By logging in, policy information will pre-fill.
- Customers who login will also have the ability to create profiles with information they always want to pre-fill in a first report of injury (such as supervisor or medical provider information).
- A copy function has been added to automatically populate information that may be the same (such as preparer, contact or address information).
- Certain fields have default values. For example, the state field defaults to Texas for all address fields.
- Search functions have been added to make it easier to find the part of body or nature of injury, when reporting a claim.

To use the enhanced online claim reporting tool:

- Go to texasınutual.com
- Click on Report an Injury in the Employer section
- Login with your username and password for policy information to pre-fill, or you have the option to skip login.

To see the redesign, a video is available at the login page. If you are not registered to use Texas Mutual online services, complete the online application at texasmutual.com, or call the Information Services Center at (800) 859-5995.

Texas Mutual Insurance Company P.O. Box 12029 Austin, TX 78711-2029 Phone: (800) 859-5995; Fax: (512)224-3889



04/14/2009

C E S ENVIRONMENTAL SERVICES I 4904 GRIGGS RD HOUSTON TX 77021-3208

Notification Confirming Receipt of Claim

Date of Injury: 04/14/2009

Injured Worker: SITTIG, BRENT Claim Number: (b) (4)

Policy Number: 0001086044

Attached is a copy of the information you reported to Texas Mutual Insurance Company which was used to establish this claim. You may submit additional claim information to Texas Mutual Insurance Company. If you have questions regarding this report of injury please contact us at (800) 859-5995.

If your policy includes our workers' compensation health care network option you are required by law to obtain a second Employee Acknowledgement of Workers' Compensation Network Form signed by the injured worker. Please submit a copy of the signed, second acknowledgement form to Texas Mutual Insurance Company. You can find a copy of the form online at www.texasmutual.com/hcn/shtm

Below please find information that will help you through the claim process:

To submit additional claim information:

Mail to: P. O. Box 12029 Austin, Texas 78711-2029 Fax to: (512) 224-3889

To locate a treating doctor:

www.texasmutual.com/workers/iwADL.shtm

To contact the handling adjuster:

Call: (800) 859-5995

Monday - Friday; 8:00 a.m. - 5:30 p.m.

To obtain a copy of the Employer and Employee Rights and Responsibilities in the Workers' Compensation System:

www.texasmutual.com/employers/erRights.shtm

To locate a pharmacy, or for pharmacy questions, contact Scripnet:

Call: (888) 880-8562 www.scripnet.com To obtain a copy of the Employer and Employee Rights and Responsibilities for the workers[†] comp health care network:

www.texasmutual.com/hcn/hcn.shtm

Additional Texas Mutual® online services at www.texasmutual.com, available 6 a.m. - 9 p.m., include:

- o Obtain logon id, or for immediate logon id, call (800) 859-5995, M-F, 8:00 a.m. 5:30 p.m.
- o Submit first report of injury in the Employers section
- o Submit wage statement when reviewing loss runs and claim details
- Obtain specific claim summary information



Claim Number: 99K0000566892

Notification Date: 04/14/2009

EMPLOYER'S FIRST REPORT OF INJURY

INJURED EMPLOYEE **BUSINESS/EMPLOYER** Name: BRENT SITTIG Name: CES ENVIRONMENTAL SERVICES I SSN: Address: Mailing 4904 GRIGGS RD HOUSTON TX 77021-3208 Address: **Phone:** (713)676-1460 **Ext:** Fax: (713)676-1676 County: CHAMBERS Policy Number: 0001086044 **Physical** Address FEIN: 760592985 Location ID: County: CHAMBERS **EMPLOYMENT** Home Phone (b) (4) Occupation: DRIVER Dire Date: DRIVER Date of Birth State: TX Marital Status: Not Married Partner/Officer/Owner: Gender: Male Dependents: 05 Date Lost Time Began: 00/00/0000 Language: Return to Work Date: English 00/00/0000 Last Paycheck was: MEDICAL PROVIDER Wage: Frequency: Hourly Name: Tax ID: Hours/Week: Days/Week: Period Start: 00/00/0000 Period End: 00/00/0000 Address: Supervisor Name: RYAN THOMAS **Phone:** (281)610-5621 Ext: Phone: Fax: PREPARER OF REPORT **ATTORNEY** Name: THANGUDU PRABHAKAR Represented by Attorney: **Phone:** (713)676-1460 **Ext:** Fax: Name: Email: Phone: **INJURY INFORMATION Date of Injury:** 04/14/2009 Time: 13:40 Address Where Injury Occurred: 2420 GULFWAY DR **Date Reported:** 00/00/0000 PORT ARTHUR TX 77640-4541 Nature of Injury: ALL OTHER County: JEFFERSON Witnesses: Cause of Injury: STRUCK BY/INJURED-ANIMAL Name: OR INSECT Phone: Name: UNKNOWN/ NOT Part of Body: Phone: REPORTED Name: Fatality: No Phone:

How and Why the Injury/Illness Occurred

FATALITY: EE WAS SITTING AND STARTED HAVING DISTRESS.



Claim & Information Services P.O. Box 12029

Austin, TX 78711-2029

1-800-859-5995 (512) 224-3800

Fax (512) 224-3889

April 17, 2009

C E S ENVIRONMENTAL SERVICES INC.

Please fax to (806) 798-6460

4904 GRIGGS RD

HOUSTON, TX 77021-3208

Re: Claim #:

Employee: Soc. Sec.: 99K0000566892 BRENT SITTIG 437-19-0197

Employer:

C E S ENVIRONMENTAL SERVI

Date of Injury: DWC #:

04/14/2009 PENDING

In accordance with the Division of Workers' Compensation Rules, we are requesting that you submit the information indicated below. The DWC3 and DWC6 forms are available for printing from our website, www.texasmutual.com, under services, or from the division's website, www.tdi.state.tx.us. For your convenience, a DWC3 is now available for you to complete and submit on-line. It is located on our website, www.texasmutual.com under the Employers - Loss Run & Claims Detail Section. If you need assistance with filing the DWC3 on-line please contact me. If you do not have access to the Internet, we will be happy to send you a blank form.

DWC3 EMPLOYER'S WAGE STATEMENT (Rule 128.2) - Please fax or email attachment or use the on-line version (www.texasmutual.com).

OR

DWC3SD EMPLOYER'S WAGE STATEMENT FOR SCHOOL DISTRICTS (Rule 128.7)

DWC6 EMPLOYER'S SUPPLEMENTAL REPORT OF INJURY OR ILLNESS (Rule 120.3) - Please fax or email attachment. The following time frames apply.

Within 10 days after:

- The end of each pay period in which the employee's earnings have changed as a result of the injury, OR
- The employee resigns or is terminated.

Within 3 days after:

- The employee begins to lose time from work as a result of the injury, OR
- The employee returns to work, OR
- The employee, after returning to work experiences an additional days(s) of disability as a result of the injury.

Failure to provide the required information is an administrative violation and may result in the assessment of a penalty from the Division of Workers' Compensation.

AND

EMPLOYEE ACKNOWLEDGEMENT OF WORKERS' COMPENSATION NETWORK FORM (This form(s) shall be completed, signed and submitted). Please fax or send attachment via email as soon as possible.

☐ COPY OF THE POST-ACCIDENT DRUG SCREEN RESULTS

Thank you for your prompt attention to this matter. If you have any questions, please call me at 1-800-859-5995 ext. 4716.

Sincerely,

Patricia Cummings

Catastrophic Workers Compensation Specialist

C E S ENVIRONMENTAL SERVICES I 4904 GRIGGS RD HOUSTON TX 77021-3208

Texas Mutual Insurance Company has redesigned the First Report of Injury (eFROI) section of texasmutual.com. More than 55% of all new reports of injury are submitted through the Texas Mutual Online (TMO) application. The redesign makes the first report of injury services more intuitive and easier for policyholders to use.

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- Certain fields have default values. For example, the state field defaults to Texas for all address fields.
- Search functions have been added to make it easier to find the part of body or nature of injury, when reporting a claim.

To use the enhanced online claim reporting tool:

- Go to texasmutual.com
- Click on Report an Injury in the Employer section
- Login with your username and password for policy information to pre-fill, or you have the option to skip login.

To see the redesign, a video is available at the login page. If you are not registered to use Texas Mutual online services, complete the online application at texasmutual.com, or call the Information Services Center at (800) 859-5995.

Texas Mutual Insurance Company P.O. Box 12029 Austin, TX 78711-2029 Phone: (800) 859-5995; Fax: (512)224-3889



04/23/2009

C E S ENVIRONMENTAL SERVICES I 4904 GRIGGS RD HOUSTON TX 77021-3208

Notification Confirming Receipt of Claim

Date of Injury: Injured Worker: Claim Number: 04/14/2009 SITTIG, BRENT

Policy Number:

0001086044

Attached is a copy of the information you reported to Texas Mutual Insurance Company which was used to establish this claim. You may submit additional claim information to Texas Mutual Insurance Company. If you have questions regarding this report of injury please contact us at (800) 859-5995.

If your policy includes our workers' compensation health care network option you are required by law to obtain a second Employee Acknowledgement of Workers' Compensation Network Form signed by the injured worker. Please submit a copy of the signed, second acknowledgement form to Texas Mutual Insurance Company. You can find a copy of the form online at www.texasmutual.com/hcn/shtm

Below please find information that will help you through the claim process:

To submit additional claim information:

Mail to: P. O. Box 12029 Austin, Texas 78711-2029 Fax to: (512) 224-3889

To locate a treating doctor:

www.texasmutual.com/workers/iwADL.shtm

To contact the handling adjuster:

Call: (800) 859-5995

Monday - Friday; 8:00 a.m. - 5:30 p.m.

To obtain a copy of the Employer and Employee Rights and Responsibilities in the Workers' Compensation System:

www.texasmutual.com/employers/erRights.shtm

To locate a pharmacy, or for pharmacy questions, contact Scripnet:

Call: (888) 880-8562 www.scripnet.com

To obtain a copy of the Employer and Employee Rights and Responsibilities for the workers' comp health care network:

www.texasmutual.com/hcn/hcn.shtm

Additional Texas Mutual® online services at www.texasmutual.com, available 6 a.m. - 9 p.m., include:

- o Obtain logon id, or for immediate logon id, call (800) 859-5995, M-F, 8:00 a.m. 5:30 p.m.
- o Submit first report of injury in the Employers section
- o Submit wage statement when reviewing loss runs and claim details
- Obtain specific claim summary information



Claim Number: 99K000056689201

Notification Date: 04/14/2009

EMPLOYER'S FIRST REPORT OF INJURY

INJURED EMPLOYEE BUSINESS/EMPLOYER Name: BRENT SITTIG Name: CES ENVIRONMENTAL SERVICES I SSN: Address: XXX-X(b) (4) Mailing 4904 GRIGGS RD HOUSTON TX 77021-3208 Address: **Phone:** (713)676-1460 **Ext: Fax:** (713)676-1676 County: Policy Number: 0001086044 Physical Address: FEIN: 760592985 Location ID: County **EMPLOYMENT** Home Phone: (b) (4) Occupation: DRIVER Date of Birth: Hire Date: State: TX Marital Status: Not Married Partner/Officer/Owner Gender: Dependents: 05 Male Date Lost Time Began: 00/00/0000 Language: English Return to Work Date: 00/00/0000 Last Paycheck was: MEDICAL PROVIDER Wage: <mark>(b)</mark> Hourly Frequency: Name: Hours/Week: Tax ID: Days/Week: Period Start: 00/00/0000 Period End: 00/00/0000 Address: Supervisor Name: RYAN THOMAS **Phone:** (281)610-5621 Ext: Phone: Fax: PREPARER OF REPORT **ATTORNEY** Name: THANGUDU PRABIJAKAR Represented by Attorney: **Phone:** (713)676-1460 **Ext:** Fax: Name: Email: Phone: INJURY INFORMATION **Date of Injury:** 04/14/2009 Time: 13:40 Address Where Injury Occurred: 2420 GULFWAY DR **Date Reported:** 00/00/0000 PORT ARTHUR TX 77640-4541 Nature of Injury: ALL OTHER County: JEFFERSON Witnesses: Cause of Injury: STRUCK BY/INJURED-ANIMAL Name: OR INSECT Phone: Name: UNKNOWN/ NOT Part of Body: Phone: REPORTED

Name:

Phoue:

How and Why the Injury/Illness Occurred

No

Fatality:

FATALITY: EE WAS SITTING AND STARTED HAVING DISTRESS.

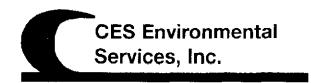
Send the specified copies to your Workers' Compensation Insurance Carrier and the injured employee. *Employers - Do not send this form to the Texas Workers' Compensation Commission, unless the Commission specifically requests a direct filing.

| TWCC CLAIM # | |
|-----------------|---|
| CARRIER'S CLAIM | # |

| Name (Last, First, M.) | | 2. Sex | TEN S FINS F | | DF INJURY OR ILLNI 15. Date of Injury | 16. Time of Injur | v I17. Date Ins | t Time |
|--|--|--|--|--|---|--|---|----------------------|
| ittia, Char | les B. | 4.54. | □ F 🛛 M | | 4-14-09 | 1 | 11 | |
| Social Security No | 4 Home Phon | a le Data | of Sirth | _ | 18. Nature of injury* | am 19. Part of Body | on Spiured or Even | end* |
| (4) | (b) (4) | | | i | | | _ | seu |
| | | | | | Death | Dea | - | 1.00 |
| Does the Employee Spa | | ivo, Specify | Language | Ť | 20. How and Why Injur | ry/Illness Occurred and surt to | hospital | bylane |
| Race | 8. Ethnicity | . 1 | | | 23. Address Where Inj | - | | |
| Caucasian | or P.O. Box | JA | | | Name of business | if incident occurred the common of the commo | d on a business Zip Zip | nutel Sa |
| (4) | 0. | | | | Post Arethus | TX | 77 | 640 |
| (4) | State | 7in | County | | 24. Cause of Injury(fall | | | |
|), Marital Status: | | | | | Pending. | investigati | ·M | |
| . Number of Dependent (| Children | 12. Spo | use's Name | 7 | 25. List Witnesses: | | | |
| | | | | | Glen Ols | <u>m</u> | | |
| Doctor's Name: Chr | | | | | 26. Return to work | 27. Did employe | 1 ' | 28. Date |
| Doctor's Mailing Addres | is (Street or P.O. | БОХ) <u>-</u> | | | Date/or expected | die? | visor's name | Reported |
| | | | | 1 | 1 .1. | 1 1 1 | Kyan | 11.11 |
| | | | | | l NLA | 424 | | U-14-84 |
| Dest Assile | State | Zip | 110 | | NA | Yes | Thomas | 4-14-69 |
| Port Arothun | State 77 | Zip 776 | ,40 | | NA | 785 | | 4-4-69 |
| POTATION | State 77 | 776 ree hired or | recruited in | 32. Len | gth of Service in | 7 65 | Thomas | |
| Date of Hire | 77\ | 776 | recruited in | | gth of Service in | 33. Length of Se | Thomas ervice in Occup | |
| Date of Hire | 31. Was employ Texas? | 776 ree hired or | recruited in | Cur | gth of Service in | 33. Length of So | Thomas ervice in Occup. 9 4RS | |
| Date of Hire Date of Hire Date of Hire Date of Hire | 31. Was employ Texas? | 776 vee hired on ∑ Ye | recruited in | Cur 35. Oee | gth of Service in (mm/y) (b) (4) upation of Injured Work | 33. Length of So (mm/yy) 2 er Drive | Thomas ervice in Occup. 9 4RS | ation |
| Date of Hire (4) Employee Payroll Classi | 31. Was employ Texas? Illication Code 37. Full Work V Hours | vee hired or Ye Ye Veek is: Days | recruited in Precruited in Pre | 35. Occ k was: Days | gth of Service in | 33. Length of So (mm/yy) Zer Deny vner, Partner, or C | Thomas ervice in Occup. O YRS orporate Officer | ation |
| Date of Hire (4) Employee Payroli Classi Rate of Pay at this job House Weekly (4) | 31. Was employ Texas? Texas? Tication Code 37. Full Work V Hours | yee hired on ✓ Ye Veek is: Days | recruited in No No 38. Last Payche | 35. Oee ck was: Days | gth of Service in rent Position (mm/yy) upation of Injured Work 39. Is employee an Ow | 33. Length of So (mm/yy) 2 er DHN 0 mer, Partner, or C | Thomas ervice in Occup. 9 4RS orporate Officer | ation |
| Date of Hire Date of Hire Date of Hire Date of Hire Date of Payroll Classi Rate of Pay at this job Hourly Weekly Name and Title of Perso | 31. Was amploy Texas? Illication Code 37. Full Work V Hours 4/O on Completing Fo | vee hired on Veek is: Days S THE | recruited in Precruited in Pre | 35. Oce ck was: Days 5 | gth of Service in rent Position (mm/yy) upation of Injured Work 39. Is employee an Ow ne of Business | 33. Length of So (mm/yy) er | Thomas ervice in Occup. 9 4 8 5 corporate Officer 2 No | ation |
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| Date of Hire Date of Hire (4) Employee Payroli Classi Rate of Pay at this job Houston Abhakar R. 7 Business Mailing Addres 404 Gaiges Houston 263588960 Workers Compensation | Texas? Texas? Texas? Texas? Toda Texas? Texas? Texas? Texas? Texas? Texas? Texas? Texas? Texas? Texas? Texas? Texas? Texas? Texas? Texas? Texas. | vee hired or Veek is: Days Number Tel No: Zip 45. Prim (SiC) | Recruited in No No No No No No No No No No No No No | 35. Oee ck was: Days 5 41. Nan Put 43. Bus City Put ustrial Clas | gth of Service in (b) (4) (4) (4) (4) (4) (4) (4) (4) (4) (4 | 33. Length of So (mm/yy) 2 er | Thomas ervice in Occup. O YRS orporate Officer No No Honne ddress) Zip 77 47, Texas C | ation r? ntal Savi |
| Date of Hire Date of Hire Di (4) Employee Payroli Classi Rate of Pay at this job Hourity Weekly Name and Title of Perso Pabhaker R. 7 Business Mailing Address 404 Gniggs Houston 263588960 Workers' Compensation Did you request accident | Texas? Texas? Texas? Texas? Toda Texas? Texas? Texas? Texas? Texas? Texas? Texas? Texas? Texas? Texas? Texas? Texas? Texas? Texas? Texas? Texas? Texas and Velephone Texas and V | vee hired or Veek is: Days Number Tel No: Zip 45. Prim (SIC) iany | Recruited in No No No No No No No No No No No No No | 35. Oce ck was: Days 5 41. Nan 24 City City 49. Police | gth of Service in rent Resition (mm/yy) upation of Injured Work 39. Is employee an Own ne of Business Asthus (homi- iness Location (If differences Location Asthus State 46. Specific (4 digit) | 33. Length of So (mm/yy) 2 er | Thomas ervice in Occup. O YRS orporate Officer No No Honne ddress) Zip 77 47, Texas C | ation r? ntal Savi |
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You may be entitled to know what information UT Arlington (UTA) collects concerning you. You may review and have UTA correct this information according to procedures set forth in UT System BPM #32. The law is found in sections 552.021, 552.-23 and 559.004 of the Texas Government Code.

Continued on next page



4904 Griggs Road Houston, TX 77021 Phone: (713) 676-1460 Fax: (713) 676-1676

Fax

| To: TX Mutual | From: Pi | rabhakar R. Thangudu |
|---------------------------|----------|--------------------------------------|
| | Eı | mail: pthangudu@cesenvironmental.com |
| Fax: 5/2-224-3889 | Pages: | 2 |
| Phone: | Date: | 4-16-2009 |
| Chardes Brent SS# (6) (4) | Sittig | |

****** Date APR-16-2009 **** Time 14:58 *******

Date/Time = APR-16-2009 14:56

Journal No. = 162

Comm. Result = OK

Page(s) = 002

Duration = 00:00:35

File No. = 839

Mode = Memory Transmission

Destination = 15122243889

Received ID =

Resolution = Fine

-CES ENVIROMENTAL -

**** DP-C264 ********** - - **** - 7137488664- *******

1503eman, Donald 7-6-09

~ I

EPAHO042001723



BACK TO WORK LETTER Clear Lake Humble Silverlake Willowbrook 830 Gemini 8484 Will Clayton Pkwy. 9430 Broadway Street 18220 Tomball Parkway Houston 77058 **Humble 77338** Suite 120 Houston 77070 (713) 442-4500 (713) 442-2000 Pearland 77584 (713) 442-1500 (713) 442-7400 Clear Lake Medical Center Katy Woman's Center 17448 Highway 3 21660 Kingsland Blvd. St. Luke's Medical Tower 7900 Fannin, Suite 2100 Webster 77598 Katy 77450 6624 Fannin Houston 77054 (713) 442-4300 (713) 442-4100 Houston 77030 (713) 442-7300 (713) 442-0000 Copperfield Kingwood The Woodlands 8470 Highway 6 N. 2755 W. Lake Houston Pkwy. Spring Medical & 17350 St. Luke's Way Easton Commons Place Kingwood 77339 **Diagnostic Center** Suite 150 and 200 Houston 77095 (713) 442-2100 15655 Cypress Woods Medical Drive The Woodlands 77384 (713) 442-4000 Suite 100 (713) 442-1800 Main Campus Houston 77014 Fort Bend Medical & 2727 W. Holcombe Blvd. (713) 442-1700 The Woodlands OB/GYN **Diagnostic Center** Houston 77025 17198 St. Luke's Way 11555 University Blvd. (713) 442-0000 West Suite 540 Sugar Land 77478 1111 Augusta Dr. The Woodlands 77385 (713) 442-9100 Pasadena Houston 77057 (713) 442-1900 3508 E. Pasadena Frwy. (713)442-2400 **Houston Center** Pasadena 77503 1221 McKinney, Suite 300 (713) 442-7100 Houston 77010 (713) 442-4700 PARIN BODINAN

| F 38 79 8 16 | and the second of the second | was was | seen/assessed by phone | . at |
|-----------------------------|------------------------------|-------------|-------------------------------------|------|
| Kelsey-Seybo work/school | on <u>1/1/1/1</u> | 7/9/09 | and may retur | n to |
|) | No Restrictions | | | |
| Ĺ | Restrictions (see | e comments) | | |
| Comments: _ | | | | |
| Date: | 7/6/09 | BANN. | 710 MM Philips | |
| | | DUN 113 | MM MM Physician Signa 440 - 0911 | iure |

White / Patient Canary / Chart

Carrillo, Rolando 7-10-09

EPAHO042001725

7-10-09 Per Jenny

Neupark Collect Jenny and informed, Rudy
Carrillo took off with his trailer tranker while it is
Still being unloaded. Apparently someone waved
Rolando off before he took off but that was
be not the Case. No one was hust and the
event happened in containment. CES sent
Rolando for drug and dichot test.

. 713 - 973 - 7947



Employer's Authorization for Examination or Treatment

| Centers | | |
|--|--|--|
| Patient Name: Relande Carphillo | AT TIME OF SERVICE) SSN | |
| | | |
| Company Name: CES Environmental S 4904 Griggs Ro | cl | |
| Location #/Street Address. Houston, TX 770 | 21 Date of figury | |
| Temporary Staffing Agency: (713) 676-1460 | 0 | |
| WORK-RELATED / INJURY ILLNESS | DOT PHYSICAL | |
| Post-Accident Substance Abuse Testing: | Preplacement | |
| Drug Screen | Recertification | |
| Breath Alcohol | Exit | |
| Drug Screen and Breath Alcohol | Audiogram | |
| Urine Collection Only | Regulated Drug Screen | |
| | Urine Collection Only | |
| DOT Regulated | Breath Alcohol | |
| Non-regulated | | |
| PRE-PLACEMENT EVALUATION | SUBSTANCE ABUSE TESTING | |
| Job Title: | Regulated | |
| Physical Exam | Non-regulated | |
| HPE | Urine Collection Only | |
| Regulated Drug Screen | Rapid Test | |
| Non-regulated Drug Screen | Pre-placement | |
| Urine Collection Only | Reasonable Suspicion | |
| Hair Collection | Random | |
| Audiogram | Periodic | |
| | Post-accident | |
| | Follow-up | |
| SPECIAL PHYSICAL EXAMINATIONS | Breath Alcohol | |
| Asbestos | The contract was | |
| Respirator | BILLING | |
| Hazmat | Employee to pay charges at time of service | |
| Baseline | Workers' Compensation | |
| Other | Insurance Co: | |
| | Policy #: | |
| | Phone #: | |
| Authorized By: Washing Thomas | Title: Manager | |
| | 0// | |
| Phone: (0) (4) | Date: 7-10-09 | |
| () | | |
| (copies of this form available at we | ww.concentranealtn.com) | |

U.S. Department of Transportation (DOT) Alcohol Testing Form (The instructions for completing this form are on the back of Copy 3)

| (The man denoted for completing this form are on the back of copy of | |
|--|--|
| STEP 1: TO BE COMPLETED BY ALCOHOL TECHNICIAN | |
| A: Employee Name Rolando Carrillo | |
| (Print) (First M (Fact) (D) (4) | 1997 (1994) 1986 - 1971 (1997) 1989 1 |
| B: SSN or Employee ID No. | |
| C: Employer Name CES Environmental | |
| City, ST ZIP 4904 GYV 1995 R.A. | |
| DER Name and One blood Visit To (a good) 201 1/22 0702 | |
| Telephone No. DER Name Telephone No. DER Phone Number | |
| D: Reason for Test: Random Reasonable Susp Post-Accident Return to Duty Follow-up Pre-employment | and the second s |
| L | |
| STEP 2: TO BE COMPLETED BY EMPLOYEE | |
| I certify that I am about to submit to altohol testing required by US Department of Transportation | |
| regulations and that the identifying information provided in the form is true and correct. | |
| Signature of Employee Date Month Day Year | |
| | |
| STEP 3: TO BE COMPLETED BY ALCOHOL TECHNICIAN | |
| (If the technician conducting the screening test is not the same technician who will be conducting the confirmation test, each technician must complete their own form.) I certify that I have conducted alcohol testing on the above named | |
| individual in accordance with the procedures established in the US Department of Transportation regulation, 49 CFR Part 40, that I am qualified to operate the testing device(s) identified, and that the results are as recorded. | |
| TECHNICIAN: BAT DSTT DEVICE: DSALIVA BREATH* 15-Minute Wait: DYes No | |
| SCREENING TEST: (For BREATH DEVICE* write in the space below anly if the testing device is not designed to print.) | |
| | |
| Test # Testing Device Name Device Serial # OR Lot # & Exp Date Activation Time Reading Time Result | |
| CONFIRMATION TEST: Results MUST be affixed to each copy of this form or printed directly onto the form. | · |
| REMARKS: | |
| | |
| | |
| Concentra ingna I-10 | |
| Alcohol Technician's Gompan O S 1/1 GE Company Street Address 70 Compa | |
| (PR) T) Alcohol Technician's Name (First, M.I., Last) Company City, State, Zip Phone Number | |
| 07,10,09 | |
| Signature of Alcohol Technician Date Month Day Year | |
| STEP 4: TO BE COMPLETED BY EMPLOYEE IF TEST RESULT IS 0.02 OR HIGHER | |
| I certify that I have submitted to the alcohol test, the results of which are accurately recorded on this | |
| form. I understand that I must not drive, perform safety-sensitive duties, or operate heavy equipment because the results are 0.02 or greater. | |
| / / | |
| Signature of Employee Date Month Day Year | |

OMB No. 2105-0529

FEDERAL DRUG TESTING CUSTODY AND CONTROL FORM



| | 800-877-748 |
|--|---|
| | |
| STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENT | LAB ACCESSION NO. |
| A. Employer Name, Address, I.D. No. | B. MRO Name, Address, Phone and Fax No. EDRE-DR STEPE EPACET FORG TO: NOA/SDECTO 7500 U 11018 OT STE 500 |
| 4994 ARISSS REAG HRESTER, TH 77022 | 1987 |
| 學學: 學學有一個子語 · 雅方心器 " 子有义 (b) (4) | |
| C. Donor SSN or Employee I.D. No. | |
| | leasonable Suspicion Cause 🔲 Post-Accident |
| E. Drug Tests to be Performed: THC, COC, PCP, OPI, AMP | THC & COC Only Other (specify) |
| LICATINE () 2630 CV MEAN E VANS | |
| en pater miss from | |
| F. Collection Site Name: | llection Site Code: Collector Phone No.: |
| City, State and Zip: KB/STEA YX 27525 | Collector Fax No.: 238-528-2562 |
| TEP 2: COMPLETED BY COLLECTOR | |
| | Collection: t Single None Provided (Enter Remark) Observed (Enter Remark) |
| REMARKS | Congression Home Provided (Enter Hernany) Conserved (Enter Hernany) |
| TEP 3: Collector affixes bottle seal(s) to bottle(s). Collector dates seal(s) | |
| FEP 4: CHAIN OF CUSTODY - INITIATED BY COLLECTOR AND Concept that the specimen of the form was callected in the certification section on Copy 2 of this form was callected. | |
| X7 39 AM | SPECIMEN BOTTLE(S) RELEASED TO: |
| Signature of Collector Tyme of Collection | ➤ Quest Diagnostics Courier ☐ FedEx |
| (Print) Collector's Name (First, MI, Last) Date (Mo./Day/Yr.) | ☐ DHL / Airborne ☐ Other ☐ Name of Delivery Service Transferring Specimen to Lab |
| RECEIVED AT LAB: X | Primary Specimen SPECIMEN BOTTLE(S) RELEASED TO: |
| Signature of Accessioner | Yes |
| (Print) Accessioner's Name (First, MI, Last) Date (Mo./Day/Yr.) | No, Enter Remark Below |
| TEP 5: COMPLETED BY DONOR | |
| l certify that I provided my urine specimen to the collector; that I have not adulterated it in any manner; es prov <mark>ided on this form and on the label affixed to each specime</mark> n bottle is correct. | ach specimen bottle used was sealed with a tamper-evident seal in my presence; and that the information |
| · Make I do 100 | Com Chapelle Dalla |
| Signature of Donor | (PRINT) Donor's Name (First, Mi, Last) Onto (Mo/Day/Yr.) |
| (b) (4) | (4) |
| Daytime Phone N Evening Phone N | Date of Birth . |
| | Mo. Day Yr. |
| | cositive, the Medical Review Officer will contact you to ask about prescriptions and over-the-counter for your own records. THIS LIST IS NOT NECESSARY. If you choose to make a list, do so either on a NTON ON THE BACK OF ANY OTHER COPY OF THE FORM. TAKE COPY 5 WITH YOU. |
| TEP 6: COMPLETED BY MEDICAL REVIEW OFFICER - PRIMARY S | PECIMEN |
| n accordance with applicable Federal requirements, my determination/verification is: | |
| | AL TO TEST BECAUSE: ADULTERATED SUBSTITUTED |
| REMARKS | , |
| | |
| Signature of Medical Review Officer (PRINT |) Medical Review Officer's Name (First, MI, Last) Date (Mo./Day/Yr.) |
| TEP 7: COMPLETED BY MEDICAL REVIEW OFFICER - SECONDAR | |
| In accordance with applicable Federal requirements, my determination/verification for the split sp | |
| ☐ RECONFIRMED ☐ FAILED TO RECONFIRM - REASON | |
| | , , |
| Signature of Madical Parious Officer (DDINT) | 3 Modical Review Officer's Name (First MI Leet) |

Companion Claim to 99 K0000566892

Send the specified copies to your Workers' Compensation Insurance Carrier TWCC CLAIM # and the injured employee. *Employers - Do not send this form to the Texas Workers' Compensation Commission. unless the Commission specifically requests CARRIER'S CLAIM # a direct filing. EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS Name (Last, First, M.L) 15. Date of Injury 16. Time of Injury 17. Date Lost Time 5UZ1 [12] F □ M am 12 pm 5. Date of Birth 19. Part of Body Injured or Exposed* 20. How and Why Injury/Illness Occurred*
Knew a Coworker that Collapsed If No. Specify Language Yes ☐ No 7. Race 8. Ethnicity 23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site NA Cancasian PostAnthus 24. Cause of Injury(fall, tool, machine, etc.)* Grief Couresling 10. Marital Status: 11. Number of Dependent Children 25. List Witnesses: 12. Spouse's Name weathers Baian ununun 13. Doctor's Name: 28. Superavailable 27. Did employee 28. Date 26. Return to work visor's name 14. Doctor's Mailing Address (Street or P.O.Box) Date/or expected Reported BHAN NA weater City State Zip 31. Was employee hired or recruited in 32. Length of Service in 33. Length of Service in Occupation (mm/yy)/10 6 Yes Texas? Current Position nproyee Fayron Classification Code 35. Occupation of Injured Worker 38. Last Paycheck was: 39. is employee an Owner, Partner, or Corporate Officer? Days Hours Yes Name and Title of Person Completing Form 11. Name of Business Post Atothus Chemical and Env Svcs LLC

36. Rate of Pay at this job | 37. Full Work Week is: 42. Business Mailing Address and Telephone Number 4904 Goinggs Road Tel No 43. Business Location (If different from mailing address)
2420 South Gulfway Drive Tel No: 7/3-676-1460 77640 Houston Federal Tax Identification Number 45. Primary Standard Industrial Classification 46. Specific SIC Code 47. Texas Comptroller Tax (4 digit) Z810 2819 (SIC) Code* (4 digit) 49. Policy Number 48. Workers' Compensation Insurance Company TSF 000 108 6044 50. Did You request accident prevention services in past 12 months? V Yes No If yes, did you receive them? Yes No 51. Signature HONS ON INSTRUCTION SHEET BEFORE SIGNING)

You may be entitled to know what information UT Arlington (UTA) collects concerning you. You may review and have UTA correct this information according to procedures set forth in UT System BPM #32. The law is found in sections 552.021, 552.-23 and 559,004 of the Texas Government Code.

Continued on next page

******* -IND. XMT JOURNAL- ********* DATE APR-22-2009 ***** TIME 16:17 *******

DATE/TIME = APR-22-2009 16:12

JOURNAL No. = 063

COMM. RESULT = OK

PAGE(S) = 002

DURATION = 00:00:36

FILE No. = 607

MODE = MEMORY TRANSMISSION

DESTINATION = 15122243889

RECEIVED ID =

RESOLUTION = STD

-CES Environmental Service-

***** DP-3010 ************* - 713 676 1676- ********



4904 Griggs Road Houston, TX 77021 Phone: (713) 676-1460 Fax: (713) 676-1676

Fax

| To: Patricia Cummings | From: | Prabhakar F ^(b) ⁽⁴⁾ | R. Thangudu | |
|------------------------------------|-----------------|--|---------------------------|--|
| Fax: 512-224-3889 | Pages: | | gudu@cesenvironmental.com | |
| Phone: 1-801-859-5995 ² | 対・4716 Date: | | 4-22-09 | |
| Companion | Chi- | m to | (b) (4) | |

Please let me know if you have any questions.

Tranks

Parlam



04/23/2009

C E S ENVIRONMENTAL SERVICES I 4904 GRIGGS RD HOUSTON TX 77021-3208

Notification Confirming Receipt of Claim

Date of Injury:

04/14/2009

Injured Worker: Claim Number: MOCK, SUZI

Claim Number: Policy Number:

0001086044

Attached is a copy of the information you reported to Texas Mutual Insurance Company which was used to establish this claim. You may submit additional claim information to Texas Mutual Insurance Company. If you have questions regarding this report of injury please contact us at (800) 859-5995.

If your policy includes our workers' compensation health care network option you are required by law to obtain a second Employee Acknowledgement of Workers' Compensation Network Form signed by the injured worker. Please submit a copy of the signed, second acknowledgement form to Texas Mutual Insurance Company. You can find a copy of the form online at www.texasmutual.com/hcn/shtm

Below please find information that will help you through the claim process:

To submit additional claim information:

To locate a treating doctor:

Mail to: P. O. Box 12029 Austin, Texas 78711-2029 Fax to: (512) 224-3889 www.texasmutual.com/workers/iwADL.shtm

To contact the handling adjuster:

Call: (800) 859-5995

Monday - Friday; 8:00 a.m. - 5:30 p.m.

To obtain a copy of the Employer and Employee Rights and Responsibilities in the Workers' Compensation System:

www.texasmutual.com/employers/erRights.shtm

To locate a pharmacy, or for pharmacy questions, contact Scripnet

Call: (888) 880-8562 www.scripnet.com

To obtain a copy of the Employer and Employee Rights and Responsibilities for the workers' comp health care network:

www.texasmutual.com/hcn/hcn.shtm

Additional Texas Mutual® online services at www.texasmutual.com, available 6 a.m. - 9 p.m., include:

- o Obtain logon id, or for immediate logon id, call (800) 859-5995, M-F, 8:00 a.m. 5:30 p.m.
- o Submit first report of injury in the Employers section
- o Submit wage statement when reviewing loss runs and claim details
- o Obtain specific claim summary information



Claim Number: 99H

99K000056689202

Notification Date: 04/22/2009

EMPLOYER'S FIRST REPORT OF INJURY

INJURED EMPLOYEE BUSINESS/EMPLOYER Name: SUZI MOCK Name: CESENVIRONMENTAL SERVICES I SSN: XXX-XX Address: Mailing 4904 GRIGGS RD HOUSTON TX 77021-3208 Address: Phone: (713)676-1460 Ext: Fax: (713)676-1676 County **Policy Number:** 0001086044 **Physical** Address FEIN: 760592985 Location ID: County: (b) (4) **EMPLOYMENT** Home Phone: Occupation: Hire Date: (b) (4) Date of Birth: (b) (4) State: TX Marital Status: Unknown Partner/Officer/Owner: Gender: Dependents: 00 Female Date Lost Time Began: 00/00/0000 Language: English Return to Work Date: 00/00/0000 Last Paycheck was: **MEDICAL PROVIDER** Wage: Frequency: Hourly Name: Tax ID: Hours/Week: Days/Week: Period Start: 00/00/0000 Period End: 00/00/0000 Address: Supervisor Name: BRIAN WEATHERS Phone: Ext: Phone: Fax: PREPARER OF REPORT ATTORNEY Name: PRABHAKAR R THANGUDU Represented by Attorney: **Phone:** (713)676-1460 **Ext:** Fax: (713)676-1676 Name: Email: Phone: **INJURY INFORMATION** Address Where Injury Occurred: **Date of Injury:** 04/14/2009 Time: 00:00 2420 SOUTH GULFWAY DR **Date Reported:** 04/22/2009 PORT ARTHUR TX 77640 Nature of Injury: MENTAL STRESS County: Witnesses: Cause of Injury: MISC, CAUSES-OTHER Name: BRIAN WEATHER MISCELLANEOUS, NOC Phone: Name: UNKNOWN/ NOT Part of Body: Phone: REPORTED

Name:

Phone:

How and Why the Injury/Illness Occurred

No

GRIEF. KNEW A COWORKER THAT COLLAPSED PER DWC-1. NLT.

Fatality:

Employee - You are required to report your injury to your employer within 30 days if your employer has workers' compensation insurance. You have the right to free assistance from the Texas Workers' Compensation Commission and may be enutted to certain medical and income benefits. For further information call your local Commission field office or 1(800)-252-7031.



Trabajador - Es necesario que usted reporte su tesión a su empleador dentro de 30 días a partir del día en que se lestorio, si su empleador liene seguro de compensación para trabajadores la ofrece asistencia grafulta, también puede que ustad tenga derecho a ciertos beneficios médicos y monotarios. Para mayor información liama a la ofrena local de la Comisión 1-800-252-7031.

| | | | KS COMPENS | | VOINI | פין | | <u>=,</u> | | | | | |
|--|-----------------------------------|-----------------|-------------------------------------|------------------------------|---------------|----------------------------|--|------------|--|--|--|--|--|
| PART 1: GENERA | AL INFORMATIO | N | 6. Coctor's Name and C Sei Cahng | - | | : | (for transmission purposes only) Cele Being Sens 5 - 4-09 | | | | | | |
| 1. Injured Emoloyee's Nam | · /^~ | 11 | 8. Clinic/Facility Name | | | r | Employer's Name | ╼╢ | | | | | |
| <u>>L17/1</u> | 100 Se | <u>«</u> | Sei chang | | | | CES Encilomental |) | | | | | |
| 2. Date of injury (b) | (4) | | Clinic/Facility/Doctor | | /A | 10. | Entelloyer's Fax # or Email Address (Il known) | | | | | | |
| 4. Employee's Description | o/ Injury/Acadeni | | 8. Clinic/Facility/Dector | -2295 fax 7(| 69-3373 | | 113 148-8664 Insurance Carrier | | | | | | |
| Exw & | £ 6. (-k) | | 515 Archi | | Texas Mutual | | | | | | | | |
| Die 10 | دین که استان مهاری سرور | | City V-1dor | State Zip 77662 | 2 | 13 | Certier's Fax 8 or Erroll Address (If known) 512 224-388 9 | | | | | | |
| BART II MORK | | | | | | | | | | | | | |
| PARTIE WORK | STATUS INFORM | ALION (F | JILLY COMPLETE ONE II | NCLUDING ESTIMATE | D DATES AN | Đ | DESCRIPTION IN 13(c) AS APPLICABLE) | | | | | | |
| 13. The injured employee's medical condition resulting from the workers' compensation injury: [] (a) will allow the employee to return to work as of (date) without restrictions. | | | | | | | | | | | | | |
| (b) will allow expected | v the employee to to last through | lo return t | o work as of (date). | (date) <u>with</u> | the restri | cti | ons identified in PART III, which | ı are | | | | | |
| (c) has prev | ented and still pr | events the | employee from ret | urning to work as | 01 5-4 | H | (date) and is expected to cont | inue l | | | | | |
| through | 5-11-04 (date |). The foll- | owing describes ho | w this injury prev | ents the e | m | loyee from returning to work; | | | | | | |
| | | | | | | - | | | | | | | |
| PART III: ACTIVIT | Y RESTRICTION | S* (REQUI | RED IF BOX 13(6) IS (| CHECKEDI | | | | | | | | | |
| 14. POSTURE RESTI | RICTIONS (If any): | | 17. MOTION RESTR | ICTIONS (If any): | | 19 | . MISC. RESTRICTIONS (If any): | | | | | | |
| Max Hours per day: | 0 2 4 6 8 | Other | Max Hours per day: | 0 2 4 6 8 | Other | d | Max hours per day of work: | | | | | | |
| Standing | | | Walking | | | | Sit/Streich breaks of per | _ | | | | | |
| Sitting | | | Climbing stairs/ladders | | | ₫ | Must wear splint/cast at work | | | | | | |
| Knoeling/Squatting | | | Graeping/Squeezing | | | d | Must use crutches at all times | | | | | | |
| Bending/Stooping | | | Wrist Region/extension | | _ | Ы | No driving/operating heavy equipme | ent | | | | | |
| Pushing/Pulling | | | Reaching | | | | Can only drive automatic transmissi | 1 | | | | | |
| Twisting | | | Overhead Reaching | | П | No work / 🔲 hours/day work | | | | | | | |
| Other: | | | Keyboarding | | — | ٦ | in extreme hot/cold environment | | | | | | |
| 15. RESTRICTIONS S | | olicable). | Other: | | | l | at heights of on scaffolding | . | | | | | |
| L Hand/Wrist | ☐ fl Hend/Wrist | | 18. LIFT/CARRY RES | | d: | Н | Must keep | . | | | | | |
| L Arm | □ R Arm □ | Neck | ☐ May not lift/carry of | | | ٦ | ☐ Elevated ☐ Clean & Dry | —· | | | | | |
| _ | | | for more than | - | | Н | • | | | | | | |
| | | Back | | _ | | 뭐 | No skin contact with: | | | | | | |
| L Foot/Ankle | ☐ Fl Foot/Ankle | li i | May not perform a | ny iirang/carrying | | 片 | Oressing changes necessary at work | | | | | | |
| Other: | TIGHT // ample | | Other: | | | _ | No Running MEDICATION RESTRICTIONS (if an | | | | | | |
| Du - 7-1 | AH SOMA # | 30 30 | with mis | | | | | ; | | | | | |
| | | #30 5 | | | | | Must take prescription medication(s) | | | | | | |
| | ray orsma | | Trol hu piz | antial interpretations. If a | | | Advised to take over-the-counter med | | | | | | |
| restriction does not apply, | il should be disregarde | ed, if modified | duly that meets these rest | rictionis la not avaitable, | ti≃ patient : | | Medication may make drowsy (poss | 3ible | | | | | |
| should be considered to b | is off work. Note - the | se restrictions | should be rollowed outsi | de or work as well as a | WOR. | _ | safety/driving Issues) | | | | | | |
| PART IV: TREATM | ENT/FOLLOW-U | P APPOIN | TMENT INFORMAT | ION | | | | | | | | | |
| 21. Work Injury Diag | mosta information | : 22. Exp | ected Follow-up Serv | rices include: | | | | | | | | | |
| Anxtety | | | uation by the treating (| | (date) at | 1 | <u>ා : ^{නිථ} (ක</u> හි pm | | | | | | |
| | | | mai to/Consult with _ | | | | | /pm | | | | | |
| Depression | | - D Phys | sical medicineXp | er week for wee | eks starting | on | (date) at ; an | п√ртп | | | | | |
| | | . D Spec | dal studies (list): | | | m_ | (date) at : ar | n√pm | | | | | |
| | | ☐ None | . This is the last sche | duled visit for this pr | roblem. Al l | tris | time, no further medical care is anticip | paled | | | | | |
| Nate / Time of Visit | EMPLOYEE'S SIGN | JAYURE | DOCTOR'S SIGNA | ATURE | Visit Type: | Ī. | Role of Doctor. Treating doc | lor | | | | | |
| 5-4-09 | | | | John - P. | 10 Initial | ď | Designated doctor Referral doct | | | | | | |
| Ascharge Time | 11) W/2- 1 | 1000 10 | Decemen | 7 7 | Follow-u | _{IP} | Carrier-selected RME 🔲 Consulting d | loctor | | | | | |
| 4.T | + | | <u> </u> | 1 | 1 | : H | TWCC-selected RME Other doctor | | | | | | |

TWCC 73 (Rev.06/00)

Hule 129.5

TEXAS MUBREDS, COMPENSATION COMPRESSOR

Employee - You are required to report your injury to your amployer within 30 days if your employer has workers' companisation insurance. You have the right to know assistance from the Traca Workers' Compensation Commission and may be entitled to certain medical and income benefits. For further information call your local Commission field office or 1(800)-252-7031.



Trabajador - Es recesario que usted reporte su lesión a su empleador dentro de 30 días a partir del día en que se lesionó, si su empleador tiene seguro de compensación para vabajadores, le Comisión Tejana de Compensación para Trabajadores le ofreca assistencia pratulta, también puede que visted tenga derecho a ciertos beneficios mádicas y monetarios. Para mayor información lieme a la oficina local de la Comisión 1-800-252-7031

| | | JKKEKS | COMPENS | AHON WO | KK STAL | บูช | KEPORT | | | | |
|---|------------------------------|------------------|---|-------------------------|--|-------------|---|---------------------------|--|--|--|
| PART I: GENERAL | INFORMATION | | 5 Denote Herro and Denoted to Sei Cahng | _ | | İ | (for transmission purposes only) | Date Being Sent 5-4-09 | | | |
| 1. Price and Oyan & Name | Mock | | 6. Clinic Facility Name Sei chang | Oh, M.D. | _ | 3 | CES En | viromental | | | |
| (6) (4 | Care with Museumber | | 7. Clinic/Facility/Occor | Phone & Fax | 7(0 2277 | - 11 | . Employer's Fax # or Eme | ili Address (ili known) | | | |
| 4/14/9 | | | B. Clinic/Facility/Dedor | -2295 fax | 113 748-8664 11. Inhurance Carrier 409 984-5558 | | | | | | |
| 5000 | C.c - (->17 | شز ۱۳۰۸ خ | 515 Archi | • | | | Mutual | | | | |
| | -m him | theer | City Vidor | \$1946 Z | ь 5 6 2 | 12 | Carrier's Fax or Empli | | | | |
| | トノンジンエケマ | | <u></u> | | | <u> </u> | | | | | |
| PART (I: WORK ST | | | | | | | |) AS APPLICABLE) | | | |
| | | | ork as of | | • | - | • | | | | |
| | the employee to last through | | | (date) <u>w</u> | iith the restr | <u>icti</u> | ons identified in | PART III, which are | | | |
| (c) has prevent | ted and still prev | ents the e | mployee from ret | urning to work | as of _5_ | 40 | $\frac{2}{2}$ (date) and is e | expected to continue | | | |
| through <u>5</u> | | The follow | ring describes ho | w this injury pi | revents the (| emp | oloyee from return | ing to work: | | | |
| PART III: ACTIVITY | RESTRICTIONS | * IRFOURE | TE BOX 13(b) IS | CHECKEDI | | | | | | | |
| 14. POSTURE RESTRIC | - | | . MOTION RESTR | |): | 19 | , MISC. RESTRICT | ions (If any): | | | |
| Max Hours per day: 0 | 2 4 5 9 | Other M | ax Hours per day: | 0 2 4 6 | 8 Other | I | Max hours per da | • | | | |
| Standing C | | _ \ | alking | | | | SIVStretch breaks | of per | | | |
| Sirring [| | CI | imbino stairs/ladders | | <u> </u> | | Must wear splint/ | cast at work | | | |
| Kneeling/Squatting | | G | eaping/Squeezing | | □ □ | | Must use crutches | s et all times | | | |
| Bending/Stooping \Box | | w | rist flexion/extension | | | | | ng heavy equipment | | | |
| Pushing/Pulling | | Re | eching | | <u> </u> | | | comatic transmission | | | |
| Twisting | | lo· | verhead Reaching | | | | _ | hours/day work: | | | |
| | | | yboarding | | | | | t/cold environments | | | |
| 15. RESTRICTIONS SPE | | , | her: | | | _ | at heights or or | n scaffolding | | | |
| | R Hand/Wrist | | LIFT/CARRY RES | | | ľ | Must keep | | | | |
| | _ | | May not lift/carry o | - | | ۱, | | Clean & Dry | | | |
| | _ | 3ack | for more than | - | | _ | | vith: | | | |
| _ | fi Foot/Ankle | 1 | May not perform a Other: | ny lifting/carrying |) | | Dressing changes No Running | necessary at work | | | |
| Other: | ONS (if any) | | Other: | | | ĺ | | TRICTIONS (if any): | | | |
| | + 00 mg #3 | 0 3 au | טם וילי | | | | | tion medication(s) | | | |
| | ax osma t | | | · N | | _ | | er-the-counter mads | | | |
| These restrictions are based | | | | | . Il a particular | | | nake drowsy (possible | | | |
| estriction does not apply, it sh hould be considered to be o | rould be disregarded. | if modified dul | y that meets these rest | rictions is not availat | pie, the patient | | safety/driving Issue | _ | | | |
| PART IV: TREATMEN | T/FOLLOW-UP | APPOINT | IENT INFORMAT | ION | | | • | | | | |
| 21. Work Injury Diagno: | | | led Follow-up Sen | | | | | | | | |
| Anxrety | | | ion by the treating o | | -09 (date) a | : 10 | 2: 30 mpm | | | | |
| - | | Referra | to/Consult with | Sychiating | <u>f-</u> 0 | n | (date) a | il : am/pm | | | |
| Depression | | Physica | ıl medicineXp | er week for | weeks starting | On | (date) | at : am/pm | | | |
| | | | studies (list): | | | on_ | (date) | | | | |
| | | ∐ None. | This is the last sche | duled visit for this | s problem. At | Driş | time, no further me | dical care is anticipated | | | |
| ate / Time of Visit | MPLOYEE'S SIGNAT | URE | DOCTOR'S SIGNA | | Visit Type: | 1 | Role of Dector; | Treating doctor | | | |
| 5-4-09 | < 7 | ~ • • • • | Deicus | مومر حموم | ' Mille! | - 11 | Designated doctor | Referral doctor | | | |
| scharge Time |) \ \ | 1 DUIL | المستحمرا | ١ ١ | ☐ Follow- | | ☐ Carrier-selected RN ☐ TWCC-selected RN | | | | |

TWCC 73 (Ruv.06/00)

Kule 129,5

TEXAS WORKERS! COMBENICATION COMMISSION

Matt.

On April 27, 2009, myself (Bo Cumberland) and Charles Salter went to visit the scene of the accident that occurred on April 24, 2009. This is my findings and my recommendation on what happened and what the consequences for the driver should be.

On April 24th 2009 at approximately 6:45 pm, Charles Salters was taking a load of caustic to the paper mill (Boise). While he was traveling down highway 87 going north he came into a second curve, he was taking a drink of water from a bottle and looked down for just a second to put it back into the cup holder. At that moment he crossed the white line and jerked the wheel to get the truck back on the road. When he turned to get the truck back to the center of the lane the product that was in the trailer moved to one side, causing the trailer to slide off the road and into the edge of the road. Charles tried to correct it but the rear tires caught the grass and flipped both tractor and trailer on its side causing it to slide into a light pole and into trees. After regaining conscious Charles climbed out of the truck and assessed the damages. A passing motorist stopped to render aid and called 911. DPS showed up along with the TCEQ and also began to assess the situation. TCEQ called Millsted to handle the cleanup of the caustic that was coming from the trailer. There was approximately 1500 gallons that went on the ground. Milstead had Miller Environmental suck the reaming caustic from the trailer. Suzi Mock took Charles to the hospital and tower medical sent a representative to the hospital to collect the drug and alcohol sample.

After going to the site of the accident today and going over Charles Salter testimony, I feel that there are several factors that caused the accident and they are as followed:

- 1) Speed The speed limit on the road is 70 mph and the speed limit through the curve is 50. I think Charles simply took the curve to fast and when he realized he was in trouble it was to late.
- 2) Drivers Attention Charles was tring to put his cup back into the cup holder and took his eyes off the road for just a second. Between the speed and the drivers lack of attention was probably the determining factor in the accident.

Disciplinary Action:

Charles will be suspended for one week with-out pay, pending the outcome of the alcohol and drug test. Should he fail anyone of those he will be terminated immediately?

Charles will be written up for breaking the employee mandates (Not taking care of company property).

Charles will be put on probation for 1 calendar year. Should he receive any violation, DOT or any company SOP, he will be terminated immediately.

After spending much of the day with Charles I feel that he truly regrets his mistake and has openly admitted fault. I feel that the disciplinary actions I outlined is fair. Please advise your opinion.

Bo Cumberland

Karin Charles Satter

- Tx mutud claim ##

99K0000568434

JASPER CO SHERIFF

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| Law tintary | ment and Tab | OT Use ONLY | | <u> </u> | | | | | ************************************** | 7776 | S Sec. | | <u> </u> |
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| | + ° | | | of Crash Records | : This report me as Department o | ay be submitted v | ris the CRIS W Crash Record | h Report lab Ponal, attratror ta, PO Box 149349 | nically subm | | 4.2 | · 6-64 | PAGE 1 OF 4 |
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Commercial Motor Vehicle Enforcement Supplement to the Texas Peace Officer's Crash Report Questions? Call: 512/486-5780

| Form CR-3C |
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| (Roy, 04/08) |
| (GSD-EPC) |
| Page 3 of 4 |

| X 10,001 LBS. OR | MORE | X HAZARDOUS MAT | ERIAL | 9 OR MORE F1.331 | enger Capac | ITY (DRIVER I | (CLUDED) |
|--|--|--|--|--|-------------------------------|---------------|--|
| CRASH INFORMATION | | | | - 45 - 10 | LOC# | | |
| 1. COUNTY | NEWTON | _2. CITY OR TOWN | DE | WEYVILLE | ORI# | TX 1760) | 00 |
| 3.ROAD ON WHICH (| | BLOCK# STREE | T OR ROAD NAME | ROUTE# | ROAD | i i | S CESS CONTROL ACCESS |
| 4.DATÉ OF CRASH | APRIL 2 | 4,2009 5.HOU | R6:31 | <u>X</u> | РМ | 3-NO AC(| ES5 |
| DRIVER INFORMATION 6.NAME SALTER, (| HARLES ANTHON | Ι Υ | | ZORIVER LICEN | SE CLASS | 1 2.5 | _ |
| CARRIER INFORMATION 8.VEHICLE OPERATION | X INTERSTATE O | OMMERCE INTRASTA | TE COMMERCE [| NOT IN COMM | IERCE [] | | PERSONAL |
| 9.CARRIER'S CORPOR | ATE NAME CES | ENVIRONMENTAL | | | | | |
| 10.CARRIER'S PRIMAR | Y ADDRESS | 4904 GRIGGS RD. HOU NUMBER S | JSTON, TEXAS 7 | 7021 City | <u> </u> | STATE | ZIP |
| 11.CARRIER ID TYPE | C IX US | TOOX TOO | OTHER | NONE 121.0 | ARRIER ID N | JMBER: | 869392 |
| MOTOR VEHICLE INFORMAT 13.UNIT NUMBER ON C | | NSE PLATE (b) (4) | STATE NUMBER | REGISTERED | EHICLE WEIGHT GROSS VEHICL | | |
| 9 2-LIGHT TRUCK 3-BUS (SEATS FI 4-BUS (SEATS FI 5-SINGLE UNIT | AR (ONLY IF VEHICLE (ONLY IF VEHICLE DIS OR 9-15 PEOPLE, INCL OR >15 PEOPLE, INCL TRUCK (2 AXLES, 6 TIR TRUCK (3 OR MORE AX | UDING DRIVER) JOING DRIVER) JES) | 9-TRACTO 10-TRACT 11-TRACT | TRAILER TRACTOR (BOBY) IL DR/SEMITRAILER OR/DOUBLE TRAILE OR/TRIPLE TRAILER WIN HEAVY TRIK(K | R R | BS. (CANNOT (| LASSIFY) |
| | OR 9-15 PEOPLE, INCLU OR >15 PEOPLE, INCLU D BOX | | 7-CONCRETE MIX 8-AUTO TRANSPO 9-GARBARGE/REF 10-GRAIN, CHIPS, 11-POLE 12-NOT APPLICAS | RTER USE GRAVEL | 98 | -OTHER | |
| 8.HAZARDOUS MATERIAL TRANSPORTING PLACARDA 1 DIGIT CLASS# 8 | | | YES NO HAZARDON | JS MATERIAL RIBE | | | (ES PROMITE VEHICLE FUEL TANK) |
| RAILER NUMBER 1 INFORM 9.LICENSE PLATE 09 YEAR | TX W38686 | 20.GROSS VEHICLE W REGISTERED GROS | - | | □ X | <u></u> | ILER TYPE 1-FULL TRAILER 2-SEM TRAILER 3-POLE TRAILER |
| RAILER NUMBER 2 INFORM 1.LICENSE PLATE YEAR | ATION STATE NUMBER | 22.GROSS VEHICLE W REGISTERED GROS | - | | | Γ | LER TYPE 1-FULL TRAILER 2-BEMI TRAILER 1-POLE TRAILER |
| 3.SEQUENCES OF EVENTS - SER 1 SR4 2 1 18 1-NONCOLLISION: RAN OFF R 2-NONCOLLISION: JACKKNIFE 3-NONCOLLISION: OVERTURN 4-NONCOLLISION: DOWNHILL 5-NONCOLLISON: EXPLOSION 7-NONCOLLISON: EXPLOSION 6-NONCOLLISON: SEPERATIO 6-NONCOLLISON: GOUSHMENT 10-NONCOLLISON: OTHER 11-NONCOLLISON: UNKNOWN | OAD (ROLLOWVER) RUNAWAY SO R SHIFT OR FIRE N OF UNITS MANICENTERLINE FAILURE | 12-COLLISION INVOLVING 13-COLLISION INVOLVING 14-COLLISION INVOLVING 18-COLLISION INVOLVING 17-COLLISION INVOLVING 18-COLLISION WITH WOR 19-COLLISION WITH WOR 20-COLLISION WITH OTHE 21-COLLISION WITH UNKN 98-OTHER | MOTOR VEHICLE IN PARKED MOTOR VE TRAIN PEDALCYCLE AN ANIMAL A FIXED OBJECT K ZONE MAINTENAN R MOVABLE OBJECT | HICLE CE EQUIPMENT | | 5 | SER OF AXLES |
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GENERAL

A separate commercial supplement is to be completed on each commercial motor vehicle involved in a motor vehicle crash. This supplement(s) in its be expected to the basic peace officer's crash report, A commercial motor vehicle for supplemental reporting is defined as:

- 1. Any motor vehicle or towed vehicle with a Gross Vehicle Weight Rating (GVWR) or a Registered Gross Vehicle Weight (RGVW), whichever s greater, of 10,001 lbs. or more, or any combination of vehicles where the Gross Combined Weight Reting (CiCWR) or the total RGVW of the combination is 10,001 lbs. or more.
 - 1.1 GVWR and RGVW are both defined as the weight of the fully equipped vehicle plus its net carrying capacity. The GCWR is the combined raight rating of a motor vehicle and a towed unit(s). On occasion, the GVWR and the RGVW will differ, in those situations, the greater weight value will be used to determine if this form must be completed.
 - 1.2 The GWWR of a motor vehicle normally can be found on an information plate on the driver's door or door post. The GWWR of a trailer normally can be found on an information plate near the front left portion of the traffer. If the vehicle does not have an information plate or it is likegible, use RGVW. For combination or token trailers, see 1.6 below.
 - 1.3 On vehicles registered in Texas, the RGVW is shown on the registration receipt under "gross weight," Commercial motor vehicles are required to carry the registration receipt.
 - 1.4 In the event the registration receipt is not evallable, RGVW can normally be obtained by a complete registration check. Exception: If the ven the has exempt license plates (i.e. owned by a government entity) no RGVW will be shown. In those instances: GVWR must be used
 - 1.5 If GVWR is used to determine the need to complete this supplement, GVWR for the motor vehicle and each trailer(s) must be obtained and shown in the appropriate blank(s).
 - 1.6 If RGVW is used to determine the need to complete this supplement, the RGVW should be obtained for each motor vehicle and trailer in the combination unless the combination is registered as a combination/token vehicle or as an apportional vehicle, in those situations the ficense plates will indicate combination/token or apportioned. If the vehicle is registered as a combination/other or apportioned vehicle, the reflice registered gross weight will be shown on the power unit and the trailer will not carry a RGVW. In those inelances, show the RGVW of the conbination in the power unit and show zero (0) on the trailer(s).
 - 1.7 RGVW for out-of-state vehicles and trailler(s) may be obtained from registration receipts issued by the licenting state, temporary permits, cat. cards or other documents or as in 1.4 above.
- Any bus, which shall include every motor vehicle with a seating capacity of nine (9) or more passengers (including the driver) and used for the transportation of persons. The seating capacity of a bus (excluding school buses) shall be determined by allowing one (1) passenger for each able an (16) inches of seat space. The seating capacity of a school bus shall be determined by allowing one (1) passenger for each thirderr(13) inches of seat space.
- Any motor vehicle hauling hazardous materials which is required to be placarded under the Hazardous Materials, Transportation Act.

INSTRUCTIONS FOR COMPLETION OF FORM CRB-3C

Detailed Instructions for completion of this supplement are included in the Instructions to Police for Reporting Crashes. Check Boxes (Top of Report)

Check appropriate box indicating if the vehicle was over 10,001 pounds, Hazardous Material(s), or 6 or more passenge: capacity (driver included). More than one box may be checked.

Roadway Access. Code the access control characteristics which best describes the roadway which the vehicle was maveling on at the time of the creat. Full Access Control- is an expressway or freeway where the only meens of entry to or exit from the roadway is by ramps connecting to other streets or highways. No Access Control is a street or highway where driveways provide access to and egress from adjacent properties and where cross atreets intersect at a grade. Partial Access Control- is a street or highway which does not clearly fit the above definitions. **CRASH INFORMATION (Items 1-5)**

Complete the information in this section exactly as shown on the basic report (CRB-3).

DRIVER INFORMATION (Hame 6-7)

Complete items 6 and 7 exectly as shown on the basic report (CRB-3).

CARRIER INFORMATION (Items 8-12)

Indicate whether the operation of the commercial motor vehicle at the time of this crash is defined as an intensiate, intrestate, government or personal operation. An interstate operation is one where the transportation of the property originated in one state or country and passed through or terminated in another state of country. An intrastate operation is one where the transportation of the property did not cross a state or international boundary. The bill of lading or q in and destination information may be one source available to make this determination. Government and Personal use will be determined through investigat on. Indicate the Carrier's corporate name and primary business address in items 9 and 10. The Carrier is defined as the entity responsible for the operation of the vehicle at the time of the crash. This may be the actuel owner of the vehicle or the lessee. The information should match Owner/Lessee shown on the CRB-3. Show the type of carrier identification by checking the appropriate box in item 11. Show the ID number in term 12, if applicable. MOTOR VEHICLE INFORMATION (Items 13-18)

Enter the unit number from the CRB-3 for (his motor vehicle in Item 13, Show the registration year, state and number in Item 14. Enter the GVWR and RGVW as applicable in Item 15. indicate which, GVWR or RGVW, by checking the appropriate box.

indicate the appropriate number in the box for Vehicle Type in item 16,

Indicate the appropriate number in the box for Cargo Body Style in Item 17,

Indicate by checking the appropriate box in item 18 whether this vehicle is hauting hazardous material(s). If yes, enter the class and ID numbers of the hazar louis material(s) being transported, indicate by checking the appropriate box whether hazardous materials were released (spilled, discharged, etc.) The dass and 10 numbers should be obtained from the bill of lading or shipping papers. If unavailable, the class and 10 numbers may be taken from the placers. The class may be located in the lower comer of the diamond shaped placerd. The ID numbers may be located on the placerd or on an orange label

near the placerd, (REFER TO DETAILED INSTRUCTIONS).

TRAILER NUMBER 1 & 2 INFORMATION (Item 19-22)

If the commercial motor vehicle reported on this supplement is towing one traffer, complete traffer number 1 section only, it (swing 2 trailers, complete both trailer number 1 and 2 sections.

Indicate the registration year, state, and number in from 19, and if applicable from 21. Show the GWW or RGVW in item 22 and, if applicable, item 22. Indicate which, GVWR or RGVW by checking the appropriate box.

Indicate the appropriate number in the box for Trailer Type (Item 20, and if applicable, item 22).

Indicate Sequence of Events (from 23), Indicate the order and type of crash events which occurred involving this vehicle.

Indicate the Total Number of Axies (Item 24), indicate the total number of axies on the motor vehicle. (Do not include trailer axies)

Indicate the Total Number of Tires (Itam 26), Indicate the total number of tires on the motor vehicle. (Do not include trailer tires)

The porson completing this supplement should print name, show department and the date this supplement was prepared in from 26.



04/29/2009

C E S ENVIRONMENTAL SERVICES I 4904 GRIGGS RD HOUSTON TX 77021-3208 pthangudu@cesenvironmental.com

Notification Confirming Receipt of Claim

Date of Injury:

Injured Worker:

Claim Number: Policy Number:

04/24/2009

SALTER, CHARLES A

(b) (4) 0001086044

Attached is a copy of the information you reported to Texas Mutual Insurance Company which was used to establish this claim. You may submit additional claim information to Texas Mutual Insurance Company. If you have questions regarding this report of injury please contact us at (800) 859-5995.

If your policy includes our workers' compensation health care network option you are required by law to obtain a second Employee Acknowledgement of Workers' Compensation Network Form signed by the injured worker. Please submit a copy of the signed, second acknowledgement form to Texas Mutual Insurance Company. You can find a copy of the form online at www.texasmutual.com/hcn/hcn.shtm

Below please find information that will help you through the claim process:

To submit additional claim information:

Mail to: P. O. Box 12029 Austin, Texas 78711-2029 Fax to: (512) 224-3889 To locate a treating doctor:

www.texasmutual.com/workers/iwADL.shtm

To contact the handling adjuster:

Call: (800) 859-5995

Monday - Friday; 8:00 a.m. - 5:30 p.m.

To obtain a copy of the Employer and Employee Rights and Responsibilities in the

Workers' Compensation System:

www.texasmutual.com/employers/erRights.shtm

To locate a pharmacy, or for pharmacy questions, contact Scripnet:

Call: (888) 880-8562 www.scripnet.com To obtain a copy of the Employer and Employee Rights and Responsibilities for the workers' comp health care network:

www.texasmutual.com/hcn/hcn.shtm

Additional Texas Mutual® online services at www.texasmutual.com, available 6 a.m. - 9 p.m., include:

- o Obtain logon id, or for immediate logon id, call (800) 859-5995, M-F, 8:00 a.m. 5:30 p.m.
- o Submit first report of injury in the Employers section
- Submit wage statement when reviewing loss runs and claim details
- Obtain specific claim summary information



Claim Number: 99K0000568434

Notification Date: 04/29/2009

EMPLOYER'S FIRST REPORT OF INJURY

| INJURED EMPLOYEE | BUSINESS/EMPLOYER |
|--|--|
| Name: CHARLES A SALTER SSN: XXX-X (b) Mailing Address: (b) (4) | Name: C E S ENVIRONMENTAL SERVICES I Address: 4904 GRIGGS RD HOUSTON TX 77021-3208 |
| County: (b) (4) Physical Address: (b) | Phone: (713)676-1460 Ext: Fax:(713)676-1676 Policy Number: 0001086044 FEIN: 760592985 Location ID: |
| County: MOBILE Home Phone: (b) (4) Date of Birth: (b) (4) Marital Status: Unknown Gender: Male Dependents: 00 Language: English MEDICAL PROVIDER | EMPLOYMENT Occupation: DRIVER Hire Date: (b) (4) State: TX Partner/Officer/Owner: No Date Lost Time Began: 00/00/0000 Return to Work Date: Last Paycheck was: Wage: Frequency: |
| Name: Tax ID: Address: | Hours/Week: Period Start: 00/00/0000 Period End: 00/00/0000 Supervisor Name: BO CUMBERLAND |
| Phone: Fax: | Phone: Ext: PREPARER OF REPORT |
| ATTORNEY | Name: PRABHAKAR R THANGUDU |
| Represented by Attorney: Name: Phone: | Phone: (713)676-1460 Ext: Fax: (713)676-1673 Email: pthangudu@cesenvironmental.com |
| | FORMATION |
| Date of Injury: 04/24/2009 Time: 18:45 Date Reported: 04/24/2009 | Address Where Injury Occurred: 87 N HWY |
| Date Reported: 04/24/2009 Nature of Injury: UNKNOWN/NOT REPORTED | TX |
| Cause of Injury: MOTOR VEHICLE-VEHICLE UPSET | County: Witnesses: Name: Phone: |
| Part of Body: UNKNOWN/ NOT REPORTED | Name: Phone: |
| Fatality: No | Name: Phone: |

How and Why the Injury/Illness Occurred

NO INJURIES. TRUCK TURNED OVER WHEN HE WAS MAKING A SHARP TURN.

NJ 07303-2017

ABOVE ADDRESS ONLY FOR RETURNS

Red Petrusit

CES ENVIRONMENTAL SERVICES INC 4904 GRIGGS RD HOUSTON TX 77021

Remittance -

COMMERCE AND INDUSTRY INSURANCE CO.

Insured: CES ENVIRONMENTAL SERVICES INC Claimant: CES ENVIRONMENTAL SERVICES INC

Producer:

REMAINDER AFTER TRUCK PAY OFF

Policy

Claim

Sym. DOL

Typ S

000005062132

01 04/24/2009 IND O **Amount** \$338.33

Charles Salter Roll-ven

Claim Office:

Use file # 684-00275583 on all correspondence, for prompt processing. For check information call: 800-242-2987

THIS DOCUMENT CONTAINS A CUSTOM COLORED BACKGROUND AS A SECURITY FEATURE COMMERCE AND INDUSTRY INSURANCE CO. Claim No.: (b) (4) 00335498 REMAINDER AFTER TRUCK PAY OFF PAY **THREE HUNDRED THIRTY EIGHT DOLLARS AND TO CES ENVIRONMENTAL SERVICES INC THE

4904 GRIGGS RD ORDER HOUSTON OF TX

JPMORGAN CHASE BANK, N.A. SYRACUSE NY.

AUTHORIZED SIGNATURE

50-937/213

07/17/2009

********\$338.33

VOID AFTER NINETY DAYS

Check No.: 10426424

No.: 10426424 RFP No.: 00335498

07/17/2009

684

10426424#

| Send to workers' compensation carrier: | |
|--|---|
| (Name and fax number of carrier) | - |



| CLAIM#_ | 99K | 0000 | 568 | 3434 |
|----------|------------|------|-----|------|
| CADDIED, | S CI AIM # | | | |

□ Initial □ Amended

EMPLOYER'S WAGE STATEMENT

The Texas Workers' Compensation Act and Workers' Compensation rules require an employer to provide an Employer's Wage Statement to its workers' compensation insurance carrier (carrier) and the claimant or the claimant's representative, if any. The purpose of the form is to provide the employee's wage information to the carrier for calculating the employee's Average Weekly Wage (AVW) to establish benefits due to the employee or a beneficiary.

The AWW is based on the wages the employee earned in the 13 weeks immediately preceding the date of injury (or the wage a similar employee earned if the employee did not work the full 13-week period). "Wages" include all forms of remuneration payable to an employee for personal services, including fringe benefits. To simplify filing, employers may file wages in a monthly, biweekly, or weekly manner as discussed below.

NOTE - An employer who fails without good cause to timely file a complete wage statement as required by the Texas Workers' Compensation Act, Texas Labor Code, Section 408.063(c) and Worker's Compensation Rule 120.4 may be assessed an administrative penalty not to exceed \$500.00 for an initial offense and not to exceed \$10,000.00 for a repeated administrative violation.

The employer shall timely file a complete wage statement in the form and manner prescribed by the Division.

- (1) The wage statement shall be filed "filed" means received) with the carrier, the claimant, and the claimant's representative (if any) within 30 days of the earliest of:
 - (A) the employee's eighth day of disability;
 - (B) the date the employer is notified that the employee is entitled to income benefits;
 - (C) the date of the employee's death as a result of a compensable injury.
- (2) The wage statement shall also be filed with the Division within seven days of receiving a request from the Division (Only When Requested).
- (3) A subsequent wage statement shall be filed with the carrier, employee, and the employee's representative (if any) within seven days if any information contained on the previous wage statement changes (such as if the employer discontinues providing a nonpecuniary wage that was initially continued after the date of injury).

All applicable DWC rules can be found at www.tdi.state.tx.us

of injury, report the wages of an employee who has training, experience,

skills & wages comparable to the injured employee AND who performs

services/tasks comparable in nature and in number of hours. If no similar

employee exists, report the limited available wages earned by the

injured employee prior to the injury.

| | | All applicable byte | Tules can be found at www.tdi.state.tx.us | | | | | | | |
|--|---|--|---|--|--|--|--|--|--|--|
| EMPLOYEE AND EMPLOYER INF | ORMATION | · · · · · · · · · · · · · · · · · · · | | | | | | | | |
| Employee's Name (Last First M.): SO I FUT (MV 1/5 | | Employer's Business Name: OFS FOVINION TO D | | | | | | | | |
| Employee's Mailing Address (Street or P.O. Roy | | Employer's Mailing Address (Street or P.O. Box): | | | | | | | | |
| Cly(b) (4) | W Code | Houston UJ | State: ZIP Code: TX THOU | | | | | | | |
| S (b) (4) | | Federal Tax I D. Number | | | | | | | | |
| Date of | Injury: | Name and Phone # of Per | son Providing Wage Information: 21 and 713-1260-1460 | | | | | | | |
| ☐ As of today's date, the employee is not ☐ The employee returned to work on | | | T this wage statement is complete, accurate, and | | | | | | | |
| ☐ without restriction. OR☐ with restrictions and is earning wage: week/month (circle one). | s of \$ per | complies with the Texas Workers' Compensation Act and applicable rules, and the listed wages include all pecuniary and nonpecuniary wages paid for (earned in) the 13 weeks prior to the date of injury (as described on page 2) and I understand that making a misrepresentation about a workers' | | | | | | | | |
| NOTE — Rule 120.3 requires the employer file Injury (DWC FORM-6) to report changes in Earnings. | | compensation of a m is a crime that can result in fines and/or imprisonment. Signature: Date: 5/0/09 | | | | | | | | |
| EMPLOYMENT STATUS AT TIME | OF INJURY (Check A | ll That Apply) | | | | | | | | |
| Full-time: employee who regularly works least 30 hours per week and whose schedule comparable to other employees of the compa and/or other employees in the same business vicinity who are considered full-time. | is employee whose work period preceding the injuous worked part-time during the part-time: Not Regi | ular Course of Conduct: | ☐ Minor: employee less than 18 years of age and not emancipated by marriage or judicial action who is also an apprentice, trainee or student. ☐ Student: employee enrolled in a course of | | | | | | | |
| ☐ Seasonal: employee who as regular course conduct engages in seasonal or cycli employment that may or may not be agricultural | of period preceding the injurial time work during that period | history for the 12-month study in high school, college or other institution shows part-time and full higher education or technical training. | | | | | | | | |
| nature and that does not continue throughout t year. | | ee who is learning a skilled al experience under the s person or artisan. | ☐ Trainee: employee undergoing systematic instruction and practice in some art, trade or profession with a view towards proficiency in it. | | | | | | | |
| SAME OR SIMILAR EMPLOYEE? | | If the employee was not er | nployed for 13 continuous weeks before the date | | | | | | | |

NOTE TO INJURED EMPLOYEE – If you were injured on or after 7/1/02, and had employment with more than one employer on the date of injury, you can provide your insurance carrier with wage information from your other employment for the carrier to include in your AWW and this may affect your benefits.

Contact your carrier for additional information or call the Division at (800) 252-7031. You can also read rule 122.5 at www.tdi.state.tx.us.

A Similar Employee (NOTE - If

DIVISION OF WORKERS' COMPENSATION

The wage information on this form is for:

requested by the Division, the employer shall identify the similar employee

The Injured Employee OR

whose wages were provided.)

| · | | | | | | | | | | | | | | | | | | |
|---|-------------------------|------|---------|-----------|--------|--------------------------|----------|---------------|---------------------|---------------------------|------------|---------------|------------|---|----------|----------------------------|-----------------------------|---|
| WAGE INFO | DRMA | TION | INSTR | UCTION | s | Employ | Po Name | 716 | , (| n He | | Social (b) | Security # | · | | | ate of Injury | <i>r</i> : |
| - The employer shall report all wages earned in the 13 weeks immediately preceding the date of injury. If the employee is paid on a monthly or semi-monthly basis, the employer may provide wages for the 3 months preceding the date of injury. Monthly wages may also be converted to weekly wages by dividing the gross monthly amount by 4.34821. If the employee is paid on a biweekly basis, the employer may provide the wages for the 14 weeks preceding the date of injury. When setting the periods to report, the employer may adjust the reporting period backward slightly (up to six days) to line up the reporting timeframes with the employer's natural pay cycle. However, the employer shall not report wages earned on or after the date of injury. - If reporting weekly earnings, use all 13 Period Columns below. If reporting 3 months of earnings, either convert the wages to weekly earnings or use the first 3 Period Columns. If reporting 14 weeks of biweekly earnings, use the first 7 Period Columns. In all cases, indicate the dates that each period covers. | | | | | | | | | | | | | | | | | | |
| Pecuniary Wages include all wages that are paid to the employee in the form of money. These include, but are not limite hourly, weekly, biweekly, monthly, etc. wages; salary; tips/gratuities; piecework compensation; monetary allowances; bonuses; commissions. Earnings are reported in the periods they are earned, NOT when they are paid and some (such as bonuses commissions) need to be prorated. Pecuniary wages don't include payments made by an employer to reimburse the employee for use of the employee's equipment or for paying helpers or to reimburse for travel expenses. Consider as earnings amounts from holidays and any vacation, personal or sick leave an employee used but not the market value of leave time earned but not used. | | | | | | | | | | | | | | s; bonuses; and es bonuses and employee for the counts from paid | | | | |
| PERIOD # (V Month #, or B | | #) | 1 | 2 | 3 | 4 | , | 5 | 6 | 7 | 8 | 9 | 10 | | 11 | 12 | 13 | |
| FROM DATE | | - | 3/15/09 | 3/20/09 | 3/2/19 | 4/5/0 | 9 4/2 | 69 4 | 19/09 | | | | | | | | | |
| TO DATE: | | - | 12/09 | 3/28/09 | 4/4/19 | 4/0/0 | 9 4/18 | 109 4 | 15/09 | | | | | | | | | TOTALS |
| # HOURS W | ORKED |): | +6.GF | W5.09 | 19.04 | 61.4 | 182 | 36 | 234 | _ | | | | | | | i | 412.28 |
| GROSS WAC EARNED: | GES | | 0) (4) | | | | | | | | | | | | | | | (b) (4) |
| NONPECUN | IIARY | WAG | E INFO | RMATIC | NC | Nonpecui benefits lis | niary Wa | ges incli | u de all w a | ages paid t e monetary | to the emp | loyee in a | form oth | er than n | noney. T | hese include ee to purc | le, but are b | not limited to, the |
| Nonpecuniary Wage Type | Emp Provide To In | | Sį | ecify Val | | | ned in E | ach Re | ported F | | r Each Be | | | | | Will E | mployer inue To vide? | Date Benefit Suspended (if suspended) |
| | YES | NO | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | YES | NO | |
| Health Insurance | | V | | | | | | | | | | | |) | | | | |
| Laundry/ Cleaning | \checkmark | | | | | | | | | | |] | | | | | | |
| Clothing/ Uniforms | / | | | | | | | | | | | | | | | | | |
| Lodging/ Housing/ | | V | | | | | | | \ | | | | | | | | | |
| Food/ Meals | | V | | | | | | _ | | | | | | | | | | |



Vehicle/ Fuel Other



4904 Griggs Road Houston, TX 77021 Phone: (713) 676-1460

Fax: (713) 676-1676

Fax

To:

From:

Prabhakar R. Thangudu

Tx mutual

Mobile: (281) 433-9792

Email: pthangudu@cesenvironmental.com

Fax:

224-3889

Pages:

Phone:

Date:

5-12-09

clain #



Tower Medical Center of Nederland

2100 Hwy. 365 Nederland, TX 77627

CES 4904 GRIGGS RD

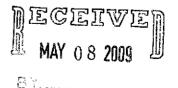
05/05/2009 Invoice #161

HOUSTON, TX 77021

| Date | POS | Code | Description | Amount |
|--|--------|---------|----------------------------|--------------------------|
| ID:1 1-64 | 81:0-1 | Name: (| JES | TX 77021 |
| Territoria (Constitution of the Constitution o | | SSN: ⊪9 | 999-99-9999 Employer: | |
| 04/25/09 | 11 | 99050 | AFTER HOURS CALL OUT | \$100.00 |
| 04/25/09 | 11 | 99082 | MILEAGE | \$11.40 |
| 04/25/09 | 11 | 5071 | DRUG SCREEN - DOT | \$45.00 |
| 04/25/09 | 11 | 4938 | EBT | \$2 5. 0 0 |
| 04/25/09 | PO | NOTE | CHARLES SALTER 417-88-5153 | |
| 04/25/09 | PO | NOTE | 1:51AM @ RENAISSANCE | |
| | | | Total for case (O | S DB): \$181.40 |

Statement Summary # Total Amount Due: \$181.40

DO NOT TURN INTO INSURANCE



| Company: | Bill ' | ro: <u>CCS</u> | <u> </u> |
|---|-------------------|-------------------------|--|
| Bill To Address: 4904 (71469) | rdi q | benton> | 1/8/27 |
| Job Site: Munton Counto#: | | Joв#: <u>///3</u> -, | 67619 |
| Authorized By Sug Made | Phone | #: 0713676 | -1460 15 |
| Testing Performed @: Ohing aung | Q | Date: <u> </u> | .09 |
| x = | | _ X Mest | tha |
| Personnel Hours Total Hours 1 X \$25.00 = \$ | 11 | X \$ <u>25.00</u> = \$_ | |
| Onsite Hours Price Charge | PFT | Price Cha | rge |
| 2. X \$ 100.00 = \$ 100.00 | | X \$ <u>25.00</u> = \$_ | |
| Call Out Fee Price (1st hour) Charge | FIT | Price Char | ge |
| 3 X \$ <u>50.00</u> = \$ | | X \$ <u>45.00</u> = \$ | |
| After 1 st hour Price Charge | • | Price Cha | |
| 4. X \$ 150.00 = \$ Charge | 14 | X \$ = \$ Price Cha | |
| 5. 19 x \$.60 = \$ 11.40 | | X \$ = \$ | _ |
| Mileage Price Charge | 15 | X \$ = \$ Price Char | |
| 6 X \$ <u>10.00</u> = \$ | | | |
| DS collection Price Charge | | | |
| 7 X \$ <u>25.00</u> = \$ | | | |
| Non DOT DS Price Charge | | ** | |
| 8. $\times $45.00 = 45.00 | TOTAL AMOU | INT DUE \$ 1814 | 0 |
| DOT DS Price Charge | | | |
| 9. X \$ 30.00 = \$ Charge | | | |
| 1 Now A | · | | |
| 10. X \$ 25.00 = \$ Charge | | | |
| COMMENTS: Charles Salter (b) (4) | | | ······································ |
| | | l | · |
| ***COMPANY MUST PAY II | N FULL. WE WILL N | OT ACCEPT INSURANCE | PAYMENT.*** |
| Arrival Time: am pm Contact Signature: | y Muc | de | |
| Depart Time: am / pm Contact Signature: | | | |



Claim & Information Services P.O. Box 12029

Austin, TX 78711-2029

1-800-859-5995 (512) 224-3800

Fax (512) 224-3889

May 4, 2009

C E S ENVIRONMENTAL SERVI 4904 GRIGGS RD HOUSTON, TX 77021-3208

Re:

Claim #: Employee:

Soc. Sec.: Employer:

C E S ENVIRONMENTAL SERVI

CHARLES A SALTER

04/24/2009

Date of Injury:

DWC #:

In accordance with the Division of Workers' Compensation Rules, we are requesting that you submit the information indicated below. The DWC3 and DWC6 forms are available for printing from our website, www.texasmutual.com, under services, or from the division's website, www.tdi.state.tx.us. For your convenience, a DWC3 is now available for you to complete and submit on-line. It is located on our website, www.texasmutual.com under the Employers - Loss Run & Claims Detail Section. If you need assistance with filing the DWC3 on-line please contact me. If you do not have access to the Internet, we will be happy to send you a blank form.

| \boxtimes | DWC3 EMPLOYER'S WAGE STATEMENT (Rule 128.2) - Please fax or email attachment or use the on-line version |
|-------------|---|
| | (www.texasmutual.com). |

OR

DWC3SD EMPLOYER'S WAGE STATEMENT FOR SCHOOL DISTRICTS (Rule 128.7)

DWC6 EMPLOYER'S SUPPLEMENTAL REPORT OF INJURY OR ILLNESS (Rule 120.3) - Please fax or email attachment. The following time frames apply.

Within 10 days after:

- The end of each pay period in which the employee's earnings have changed as a result of the injury, OR
- The employee resigns or is terminated.

Within 3 days after:

- The employee begins to lose time from work as a result of the injury, OR
- The employee returns to work, OR
- The employee, after returning to work experiences an additional days(s) of disability as a result of the injury.

Failure to provide the required information is an administrative violation and may result in the assessment of a penalty from the Division of Workers' Compensation.

AND

EMPLOYEE ACKNOWLEDGEMENT OF WORKERS' COMPENSATION NETWORK FORM (This form(s) shall be completed, signed and submitted). Please fax or send attachment via email as soon as possible.

☐ COPY OF THE POST-ACCIDENT DRUG SCREEN RESULTS

Thank you for your prompt attention to this matter. If you have any questions, please call me at 1-800-859-5995 ext. 2166.

Sincerely,

Denise Vavrina/MC

Denise Vavrina
WORKERS' COMPENSATION SPEC II



AIG Domestic Claims, Inc. Property/Casualty Division

*Property/Casualty Divi*s P.O. Box 25588

Shawnee Mission, KS 66225

(800) 242-2987

(all other) Fax (866) 723-0109 (new losses) Fax (866) 854-4926

AUTOMOBILE LIABILITY NEW CLAIM ACKNOWLEDGEMENT

April 28, 2009

CES ENVIRONMENTAL 4904 GRIGGS RD HOUSTON, TX 77021-3208 Attn: GREG BOWMAN

RE:

Insured

: CES ENVIRONMENTAL SERVICES INC

Carrier

: Commerce & Industry

Date of Loss

: <u>04/24/2009</u>

Date Reported

: 04/27/2009

Claim Number

684-275583

Date Received

: 04/27/2009

This letter will confirm receipt of the above referenced claim.

ADDITIONAL CLAIM INFORMATION:

Policy Number

: 005062132

Loss Location

: HWY 87 EVADALE,TX

Description of Loss

: I/V ROLLED OVER CAUSING DAMAGE AND SPILLOF PRODUCT FROM

TRAILER

Insured Driver

: SALTER CHARLES

RISK ANALYSIS INFORMATION:

| KINK WINTERSON | OKMATION. | | | |
|----------------|-----------|------|------|-------|
| Level 1: | _ | | | |
| Level 2: | | | | |
| Level 3: | | | _ | |
| Level 4: | | | | ' |
| Level 5: | | | | |
| Level 6: | | | | 1 |

CLAIMANT INFORMATION:

Symbol Name

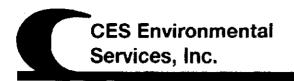
MJC

001 002 CES ENVIRONMENTAL SERVICES INC
CES ENVIRONMENTAL SERVICES INC

009 009

If you have any comments or questions, please feel free to contact me. Kindly refer to the above claim number on any correspondence.

Sincerely,
JOHN RADDATZ
CASUALTY SPEC.
251-PC OVERLAND PARK, KS
(913) 338-9310
JOHN RADDATZ@AIUHOLDINGS.COM
Original



4904 Griggs Road Houston, TX 77021 Phone: (713) 676-1460

Fax: (713) 676-1676

Fax

| To: | From: | Prabhakar R. Thangudu | | | | | |
|---------------------------------------|--------|---------------------------------------|--|--|--|--|--|
| Denise Varrina Fax: 1-512-224-3889 | Pages: | Email: pthangudu@cesenvironmental.com | | | | | |
| Phone: | Date: | 5-13-09 | | | | | |

Claim # (b) (4)

Employee Acknowledgment of Workers' Compensation Network

I have received information that tells me how to get health care under my employer's workers' compensation insurance.

If I am hurt on the job and live in a service area described in this information, Lunderstand that:

- 1. I must choose a treating doctor from the list of doctors in the network. Or, I may ask my HMO primary care physician to agree to serve as my treating doctor. If I select my HMO primary care physician as my treating doctor, I will call Texas Mutual at (800) 859-5995, extension 2880 to notify them of my choice.
- 2. I must go to my treating doctor for all health care for my injury. If I need a specialist, my treating doctor will refer me. If I need emergency care, I may go anywhere.
- 3. The insurance carrier will pay the treating doctor and other network providers.
- 4. I might have to pay the bill if I get health care from someone other than a network doctor without network approval.

| 5. Making a false or fraudulent workers' equipensation | claim is a cri | me that may result in |
|--|----------------|-----------------------|
| fines and or imprisonment. | | |
| Lac 1 H Last | ? | -16-09 |
| MCMS A MIG DOW | | Date |
| Charles L. How School | | Date |
| Siccio Aninom Source | | |
| rented Name | | |
| I live at: | | |
| (b) (4) | | |
| | State | Zip Code |
| Name of Employer: CES Env Sucs Inc | | |
| Name of Network: Tesas Star Networks | | |
| | | |
| Network service areas are subject to change, | | |
| Call (800) 381-8067 if you need a network treating | ig provider | |
| Please indicate whether this is the: | | |
| ☐ Initial Employee Notification | | |
| | | |
| Injury Notification (Date of Injury: 04/24 | 12009) | |
| 요한일 도망이 그리는 이 역사에서 대표적을 한 경험하여 한 경험을 다쳤다면 하는 것이 <mark>되어 하다는 것이다.</mark> | | |

DO NOT RETURN THIS FORM TO TEXAS MUTUAL INSURANCE COMPANY UNLESS REQUESTED

Employee Notice of Network Requirements - 03/06

Page 8 of 8

******** -IND. XMT Journal- ********* Date MAY-13-2009 ***** Time 12:04 *******

Date/Time = MAY-13-2009 12:03

Journal No. = 098

Comm. Result = OK

Page(s)

= 002

Duration

= 00:00:38

File No.

= 160

Mode = Memory Transmission

Destination = 15122243889

Received ID =

Resolution = Fine

-CES ENVIROMENTAL

***** DP-C264 ****************************

_ **** _

7137488664- *******



Claim & Information Services

P.O. Box 12029

Austin, TX 78711-2029

1-800-859-5995 (512) 224-3800

Fax (512) 224-3889

April 30, 2009

C E S ENVIRONMENTAL SERVICES I

4904 GRIGGS RD HOUSTON, TX 77021-3208

Re:

Claim #:

Employee:

Soc. Sec.:

CHARLES A SALTER

Employer:

C E S ENVIRONMENTAL SERVICES I

Date of Injury: 04/24/2009

Dear C E S ENVIRONMENTAL SERVICES I,

I represent Texas Mutual Insurance Company for the above referenced workers' compensation claim.

I have attempted to contact your office and was unable to reach you. Please contact me at your earliest convenience to discuss this claim. I can be reached at (800) 859-5995 ext. 2166. Please disregard this notification if I have spoken with you prior to your receiving this letter.

Thank you for your kind attention to this matter.

Sincerely,

Denise Vavrina WORKERS' COMPENSATION SPEC II





Claim & Information Services

P.O. Box 12029

Austin, TX 78711-2029

1-800-859-5995 (512) 224-3800

Fax (512) 224-3889

May 19, 2009

C E S ENVIRONMENTAL SERVICE 4904 GRIGGS RD HOUSTON, TX 77021-3208

Re:

Claim #:

Social Security #:

Employee:

Employer:

(b) (4) CHARLES A. SALTER

C E S ENVIRONMENTAL SERVICE

Date of Injury:

04/24/2009

Dear C E S ENVIRONMENTAL SERVICE,

Please be advised that I am now handling the workers' compensation claim referenced above.

Please contact me if, due to the injury, a change in work status occurs which results in a change in the employee's earnings.

In addition, should you have any questions concerning this claim, please call me at 1-800-859-5995 ext. 2121. I look forward to talking to you.

Sincerely,

Angie Balderas WORKERS' COMPENSATION SPEC II



Claim & Information Services P.O. Box 12029 Austin, TX 78711-2029 1-800-859-5995 (512) 224-3800

> (512) 224-3889 Fax

May 15, 2009

Ms. Anisa Wright C E S ENVIRONMENTAL SERVI 4904 GRIGGS RD HOUSTON, TX 77021-3208

Re:

Claim #:

Employee:

Soc. Sec.:

Employer:

CHARLES A. SALTER

C E S ENVIRONMENTAL SERVI

Date of Injury: 04/24/2009

DWC#:

Dear C E S ENVIRONMENTAL SERVI,

Thank you for submitting the attached Wage Statement. We have reviewed the form and have found information that must be changed to meet the requirements of the Division of Workers' Compensation. Please make the following corrections:

The wages must go back 13 weeks prior to the date of injury, not including the week of the injury. If he worked less then 13 weeks and there is not a same/similar employee then we can use the wages that the employee earned. We show a date of hire of March 26, 2009 for the employee.

Under the nonpecuniary wage information you show you provided laundry and uniforms. Please provide the amounts paid each week and on the other side of form show when this stopped.

Thank you for your prompt attention to this matter. If you have any questions, please call me at 1-800-859-5995 ext. 2166.

Sincerely.

Senise Vavrina

WORKERS' COMPENSATION SPEC II

Enclosure: Wage Statement

| • | | | ٠ ا | | • | 1 | | | |
|--|---|---|--|---|--|--|--|--|--|
| Send to workers' compensation carrier: | | | CLAIM # | 99K 0 | 1000 | 568434 | | | |
| (Name end fex rember of detrier) | | | CARRIER'S CLAIM # | | | | | | |
| □ Initial □ Amended EMPL | OYER'S WA | AGE STA | TEM | ENT | | | | | |
| The Texas Workers' Compensation Act and Worker require an employer to provide an Employer's Wage S' compensation insurance carrier (carrier) and the dali representative, if any. The purpose of the form is to pwage information to the carrier for calculating the employee Wage (AWW) to establish benefits due to the employee | s' Compensation rules talement to its workers' mant or the claimant's provide the employee's oyee's Average Weekly | manner prescribed by the Division. (1) The wage statement shall be filed ("filed" means received) with the | | | | | | | |
| The AWW is based on the wages the employee earnediately preceding the date of injury (or the wagearned if the employee did not work the full 13-week peals forms of remuneration payable to an employee including fringe benefits. To simplify filling, employer monthly, biweskly, or weekly manner as discussed below. | arned in the 13 weeks ge a similar employee arlod). "Wages" include for personal services, is may file wages in a | (B) the date (C) the date (2) The wage | e the emi efits; of the em statement | ployee's death a | I that the elections a result of lied with the | mployee is entitled to a compensable injury, Division within seven an Requested). | | | |
| NOTE - An employer who falls without good cause to wage alatement as required by the Texes Workers' Co Labor Code, Section 408.063(c) and Worker's Comper be assessed an administrative penalty not to exceed offense and not to exceed \$10,000.00 for a repeated ac | mpensation Act. Texas issation Rule 120,4 may i \$500.00 for an initial | and the empli information cor the employer of continued after | oyee's re itained on iscontinue the dale o | presentative (if the previous was a providing a no | any) within ige alalemer inpacuniary i | the carrier, employee, seven days if any at changes (such as if wage that was initially w.tdi.siate.tx.us | | | |
| EMPLOYEE AND EMPLOYER INFORM | MATION | | | | | | | | |
| Employee's Name (Last, First, M.). Soiter, Morlis | • | Employer's Bus | WIDIY | בלרושמר |) | · | | | |
| Emp (b) (4) | | Employer's Mal | ling Addre | ss (Street or P.O | · | | | | |
| City (b) (4) | P Code: | Hzyustz | 7 N | State: | , | P Code: | | | |
| Soc b) (4) | , | Federal Tax I.D | | ~~~~ | | | | | |
| Date of (b) (4) Late of Injury: | | Name and Pho | ne # of Re | rson Providing V | | 110n: 1760-1460 | | | |
| As of today's date, the employee is not back a The employee returned to work on without restriction. OR with restrictions and is earning wages of \$ week/month (circle one). NOTE - Rule 120.3 requires the employer file the \$ Injury (DWC FORM-6) to report changes in Work \$ Earnings. | and is working: per | compiles with the and the listed violent (earned in) the and in understand in the and incompile and | he Texas vages incli 13 weeks and Ithal | Workers' Compute all pecuniary prior to the date making a misi | ensation Act and nonpect of injury (as representation out in lines a | emplete, accurate, and and applicable rules, cuntary weges paid for described on page on about a worker and/or imprisonment. | | | |
| EMPLOYMENT STATUS AT TIME OF I | NJURY (Check A | Il That App | y) | | | Tổ. | | | |
| least 30 hours per week and whose schedule is comparable to other employees of the company and/or other employees in the same business or vicinity who are considered full-time. Seasonal: employee who as regular course of conduct engages in seasonal or cyclical employment that may or may not be agricultural in nature and that does not continue throughout the | Part-time: Regular perployee whose work period preceding the injustration of the period preceding the injustration of the period preceding the injustration of the period | history for the iry shows the pe hat period. ular Course of thistory for the ry shows pert-time tod. ee who is learning at expenience u | 12-morth son only Conduct: 12-morth e and full a skilled nder; the | and not ema action who is student. Student: Study in high shigher educati Trainee: instruction ans | nctpated by an a employee elschool, collegon or technic employee ud practice is | than 18 years of egg marriage or judicial pprentice, trainee or nrolled in a course of ge or other institute of all training. Indergoing systematical a some art, trade of ards proficiency in it. | | | |
| SAME OR SIMILAR EMPLOYEE? | | | | | | eeks before the dalek | | | |
| The wage information on this form is for: The injured Employee OR A Similar En requested by the Division, the employer shall identify whose wages were provided.) | nployee (NOTE - If the similar employee | | | | | | | | |
| NOTE TO INJURED EMPLOYEE - If you were injured provide your insurance carrier with wage information for Contact your carrier for additional information or call the | rom your other employm | ent for the came | r to includ | le in your AWW | and this may | ale of injury, you can y affect your benefits: | | | |
| DWC FORM-3 (Rev. 1005) Page 1 RECEIVED TIME MAY, 12. | 2:45PM | | | , | | KERS' COMPENSATION | | | |

EPAHO042001761

EPAHO042001762

WAGE INFORMATION INSTRUCTIONS

| Empl | CM TU | 5 <u>C</u> MJ | 140 | S of Security # | W-31 | | ate of injury: |
|-------|---------------|---------------|----------------|-----------------|--------------|------------|----------------|
| weeks | immediately p | receding the | date of injury | If the employee | ls paid on a | monthly or | semi-monthly b |

- The employer shall report all wages earned in the 13 weeks immediately preceding the date of injury. If the employee is paid on a monthly or semi-monthly basis, the employer may provide wages for the 3 months preceding the date of injury. Monthly wages may also be converted to weekly wages by dividing the gross monthly amount by 4.34821. If the employee is paid on a biweekly basis, the employer may provide the wages for the 14 weeks preceding the date of injury. When setting the periods to report, the employer may adjust the reporting period backward slightly (up to six days) to line up the reporting timeframes with the employer's natural pay cycle. However, the employer shall not report wages earned on or after the date of injury.
- If reporting weekly earnings, use all 13 Period Columns below. If reporting 3 months of earnings, either convert the wages to weekly earnings or use the first 3 Period Columns. If reporting 14 weeks of biweekly earnings, use the first 7 Period Columns. In all cases, indicate the dates that each period covers.

| PECUNIARY WAGE I | NFORMA | ATION | | hourly, we commission commission use of the | ekly, biwee ons. Earnin ons) need to amployee's | kiy, monthly, gs are repo be prorated. | etc. wages rted in the Pecuniary or for paying | s; salary; tip periods the wages don phelpers or | os/gratulties; y are earner 't include par to reimburs | plecework d, NOT who yments mad e for travel (| compensation they are less than they are less than the les | n; moneiar paid and s ployer to rel consider as | y allowance ome (such mburse the earnings an | re not limited to; s; bonuses; and as bonuses and employee for the nounts from paid not used. |
|---|---------|----------|--------|--|--|--|---|---|---|---|--|--|---|--|
| PERIOD # (Week #, Month #, or Bl-Week #) | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | |
| FROM DATE: | 3/5/09 | 3/20109- | 12/09- | 4/5/09 | 4/10/09- | 4/9/09- | | | | | | | | |
| TO DATE: | 30/109 | 3/28/09 | 4/4/09 | 4/1/09 | 4/18/09 | 455/09 | | | | | : | | | TOTALS |
| # HOURS WORKED: | #2.2# | 1609 | A.OH | 101.41 | 8213 | 6231 | | | | | | | | 412.28 |
| GROSS WAGES EARNED: | (b) (4) | | | | | | | | | | | | | (b) (4) |

| NONPECU | NARY | WAGE | INFO | RMATI | NC | benefits i | benefits listed below but do not include monetary allowances or stipends paid to allow the employee to purchase the benefits. | | | | | | | | | | | | |
|---------------------------|--------|-----------------------------|------|--|----|------------|---|---|---|---|---|----|----|----|---|---------|----|----------|-------------|
| Nonpecuniary Wage Type | Provid | loyet ed Prior ijury? | Sp | Specify Value Or Amount Earned in Each Reported Period For Each Benefit Provided Prior To Injury (Use the same periods as used above) Will Employer Continue To Provide? | | | | | | | | | | | Date Benefit Suspended (if suspended) |] ≥ | | | |
| | YES | NO | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | YES | NO | (| 45 |
| Health Insurance | | V | | | | | | | | | | | | | | | | | \supseteq |
| Laundryi Cleaning | V | | | | | | | | · | | | | | | | | | | , () |
| Clothing/ Uniforms | 1 | | | | | | | | | | | | | | | | | | MAY |
| Louging/ Housing/ | | V | | | | | | | | | | | | | | | | | I WE |
| Food/ Meals | | V | | | | | | | | | | | | | | | | | EIVED |
| Vehicle/ Fuel | | V | | | _ | | | | | | | | | | | | | - | |
| Other | | | | | | | | | | | | | | | | |] | | |



Joe A. Gonzales

6-25-09

CUSTODY AND CONTROL FORM (DO NOT USE THIS FORM FOR D.O.T. COLLECTIONS)

317799297



ADVANCED TOXICOLOGY NETWORK, STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE 3560 Air Center Cove, Memphis, TN 38118 (888)222-4894 A. Employer Name, Address, i.D. No. B. MRO Name, Address, Phone and Fax No. _ *00024 lexighenis - stemet moteman, mo CMC/TX-Houston I-10 tage 2 456 QUADRAMPLE DETYR STE A BOUINGERCOK, IL \$0440 Franc: (588)794-8576 FAX: (866)385-1297 CFS Environme Ind more arrays Pl SERVER 281-433-9792, flow mon. C. Don<mark>or Information Note: Donor <u>must</u> sign HIPAA auth</mark>orization on back of copy 1 D. Results Review SSN []119-NOAL ANDOR HEN-OS []10152-MOOL ANDTE MEN-OR E. Reason for Test M.I. A First Random Name ☐ Pre-employment ☐ Reasonable Suspicion/Cause Post Accident. ☐ Post Injury ☐ Return to Duty ☐ Follow-up GUNZALES Last ☐ Other (specify): □ Name F. Test to be Performed: James of Philade School topio ID (optional) Donor Tologe Drug acreem: 10 Pankl Phone 151001 9-MICA: 5 DRUG PAREL (5.15) (Daytime) JOIGEL DANG SCREEN: 9 SANGL Donor Jaucott middetti, urise .02/.02 Phone (Evening) JEIGGES DAME BURGER: S PANGL W/ Ethensi Donor Certification: TOICOR *DRING SCRI*ENT SI PANCL (2.80) certify that I provided my urine specimen to the collector, that I have not adulterated it in any manner; that each specimen bottle used was sealed with e tamper-evident seal in my presence; and that the information provided on this form and on the label affixed to each specimen bottle is correct. 0 70709 Date (MM/DD/YY) Signature of Donor G. Collection Site Information 703 (713) 973-7943 CONCENTRA MEDICAL CENTERS Collection Site Phone No. 10909 I-10 BAST PRESERY (712) 973-7947 HOUSTON, TX 77029 STEP 2: COMPLETED BY COLLECTOR Read specimen temperature within 4 minutes. Is temperature between Specimen Collection: ☐ Observed: 90° and 100° F? NO, enter remarks Split \$plit Single (Enter Remarks Below) REMARKS: STEP 3: Collector affixes bottle seal(s) to bottle(s). Collector dates seal(s). Donor initials seal(s). STEP 4: GHAIN OF CUSTODY - INITIATED BY COLLECTOR AND COMPLETED BY LABORATORY certify that the specimen given to rige by the donor identified above was collected, labeled, sealed and released to the Delivery Service noted, in accordance with applicable requirements.

Specimen BOTTLE(S) RELEASED TO:

Signisture of Collector

Time of Collecton SANCHEZ なのは何は強な PRINT Collector's Name (First MI Last) Name of Delivery Service Transferring Specimen to Laborator RECEIVED AT LABORATORY SPECIMEN BOTTLE(S) RELEASED TO: Primary Specimen Bottle Seal Intact? Yes Mo Signature of Accessione Tamperary Brorner

COPY 4 - EMPLOYER COPY

Date (MM/DD/YY)

PRINT Accessioner's Name (First MI Last)

enter remarks below

To: Dan Bowman 7136761676

Employee - You are required to report your injury to your employer within 30 days if your employer has workers compensation insurance. You have the right to tree assistance from the Texts Workers' Compensation Commission and may be shiftled to certain medical and income benefits. For further information call your local Commission field office or 1(800)-252-7031.



Trabajador - Es negesario que usted reporte su lesión a su empleador dentro de 30 dias a partir del día en que se lésionó, al su empleador tiene seguro de compensación para trabajadores. Is Comisión Tejana de Compensación para Trabajadores le otrace seistenda gratulta, tambián puede que usted tenga derecho a ciertos beneficios médicos y monetarios. Para meyor información lisme a la cificina local de la Comisión 1-800-252-7031.

| TEXAS WORKER | IS' COMPENSATION WORK STAT | US REPORT | |
|---|--|--|------------------------|
| | octors Name and Degree an T. Dolan, MD | (for transmission purposes only) | Date Being Sent |
| | ilnic/Facility Name | 9. Employer's Name | |
| | C - Houston I-10 East | CES Environmental | d |
| | Ilnic/Fadility/Doctor Phone & Fax 3)973-7949 (713)973-7947 | 10. Employer's Fax # or Email A (719)676-1676 | adrees (II Known) |
| | Inic/Facility/Doctor Address (atrest address) | 11. inaurance Carrier | |
| 1_ | 009 East Frwy | Texas Mulual Insurance Co | Moanv |
| both arms " City | State Zip | 12. Carrier'a Fax # or €mail Add | |
| Hou | ston TX 77029 | (512)224-3669 | |
| | ULLY COMPLETE ONE INCRUDING ESTIMATED DATES. | AND DESCRIPTION IN 13(c | AS APPLICABLE) |
| (b) will allow the employee to return to work expected to last through (c) has prevented and still prevents the employee | as of 07/07/2009 (date) without restrictions. | | continue |
| PART III: ACTIVITY RESTRICTIONS: (REC | QUIRED IF BOX 13(b) IS CHECKED) | | |
| 14. POSTURE RESTRICTIONS (If any) : | 17. MOTION RESTRICTIONS (If any): | 19. MISC. RESTRIC | CTIONS (If any); |
| Max Hours per day: 0 2 4 6 6 Other | Max Hours per day: 0 2 4 6 8 Other | l <u>—</u> | day of work: |
| Standing | Walking | | |
| | | = | ks ofper |
| Sitting | Climbing stairs/ladders | Must wear splin | Vcast at work |
| Kneeling/Squatting | Grasping/Squeezing | Must use crutch | ies at all times |
| Bending/Stooping | Wrist flexion/extension | No driving/oper | sting heavy equipment |
| Pushing/Pulling | Reaching | | automatic transmission |
| | | | |
| Twisting | Overhead Reaching | - - | hours/day work: |
| Other: | Keyboarding | in extreme | hat/cold environments |
| 15. RESTRICTIONS SPECIFIC TO (If applicable) | . Other: | at heights o | r on scaffolding |
| L Hand/Wrist R Hand/Wrist | 18. LIFT/CARRY RESTRICTIONS (If any): | Must keep | |
| L Arm R Arm Neck | May not lift/carry objects more thanibs | | Clean & Dry |
| | | _ _ | |
| ☐ L Leg ☐ R Leg ☐ Back | for more thanhours per day | No skin contact | with: |
| L Foot/Ankle R Foot/Ankle | May not perform any lifting/carrying | Dressing chang | es necessary at work |
| Other: | Other: | No running | |
| 16. OTHER RESTRICTIONS (If any): | | 20 MEDICATION E | ESTRICTIONS(# any): |
| To. Office Harrison one (ii Elly). | | 1 — | |
| | | | ription medication(s) |
| | | | over-the-counter meds |
| | nding of the employee's essential job functions. If a particula | | make drowsy (possible |
| restriction does not apply, it should be disregarded. It modifies the considered to be off work. Note - these restriction | ied duty that meets these restrictions is not available, the pa as should be followed outside of work as well as at work. | safety/driving iss | ues) |
| | | | |
| PART IV: TREATMENT/FOLLOW-UP APPO | | | |
| | pected Follow-up Services include: | | |
| 1082.0 Cuined Delinemie Alia Ciliel Eczenie Dies | uation by the treating doctor on 07/13/2009 | | at 09:00 am am/pm |
| Her | erral to/Consult withon sical medicineX per week forweeks starting | (date) | |
| l — — — | | on(date) | |
| | , , | t this time, no further med | |
| | | le of Doctor: | Treating doctor |
| 07/07/2009 12:37 pm | 1 " | Designated doctor | Referral doctor |
| Diacharge Time | Jeanner De-Com Mus Initial Follow-up | Carrier-selected RME | Consulting doctor |
| 07/07/2009 01:54 pm \ \ | → Im Louiow.rdb I | DWC-selected RME | ☐ Other doctor |

DWC FORM-73 (Rev. 10/05) Page 1



DIVISION OF WORKERS' COMPENSATION

Employee - You are required to report your injury to your employer within 30 days if your employer has workers' compensation insurance. You have the right to free assistance from the Texas Workers' Compensation Commission and may be entitled to certain medical and income benefits. For further information call your local Commission field office of 1(800)-252-7031.



Trabajador - Es necesario que usted repone su leción a su empleador dentro de 30 dias a partir del dia en que se lecionó, al au empleador tiene seguro de compensación para trabajadores. Ia Comisión Tejana de Compensación para Trabajadores le ofrece asistenda gratulta, también puede que usted tenga derecho a ciertos beneficios médicos y monetarios. Para meyor información llame a la oficina local de la Comisión 1-800-252-7031.

| | TEXA | S WORK | ERS' CO | MPENSATION | ON I | WORK ST | ATUS | REPORT | Γ . | _ | | | | |
|-----------------------|---|-----------------------------|-----------------------------------|---------------------------|-----------------|----------------------|-------------------|--|-------------|-----------------|-------------|--|--|--|
| PART I: GEN | NERAL INFO | RMATION | 5. Doctor's Name Jean T. Dolan | | | | | (for transmissio purposes only) | п | Date Being Sent | 1 | | | |
| 1, injured Employee's | Name | | 6. Clinic/Facility | <u>.</u> | | | 9. E | mployer's Name | | | | | | |
| Joe A. Gonzales | | | CMC Housto | n I-10 Eget | | | 3 Environmental | | | | | | | |
| 2. Date of Injury | 3. Social Security No | umber | | octor Phone & Fax | | | 10. |). Employer's Fax# or Email Address (If known) | | | | | | |
| 06/25/2009 | XXX-XX-(b) | 1 | (713)979-7943 | (713 |)973-79 | 947 | | 3)676-1676 | | , , | | | | |
| 4. Employes's Descrip | | 1 | 8. Clinic/Facility/D | loctor Address (street se | (agendo | | inaurance Carrier | | | | | | | |
| Patient states : pat | | | 10909 East Fr | wy | | | Tex | as Mutual Insura | nce Cor | TIDERIV | | | | |
| both arms " | | | City | State Z | Ip | | | . Carrier's Fax # or Email Address (it known) | | | | | | |
| | | | Houston | | 7029 | | li . | 2)224-3 00 9 | | ,, | | | | |
| PART II: WOR | IN STATUS IN | IEORMATIO | M (LIDLY CON | MPEL DE ONE INCLE | HMMG | LSUMALLSDAL | LE AND | DI SOURDHOND | M 13(a) | AS ADDITO | 01.13 | | | |
| | | | | | | | II . J AINI | THE SECOND STATE OF THE SE | ing trifari | - | ,, | | | |
| 113. The injures of | | | | he workers' comp | | | | | | | | | | |
| • • | | | | <u>//07/2009 (date)</u> | | | | | | | | | | |
| | | | | (date) | With t | ne restrictions | Ideni | lified in PART | III, Wh | lich are | | | | |
| · | d to last through | | (date). | | | | | | | | | | | |
| | | | | returning to wo | | | | | | continue | | | | |
| tnrougn | (0 | iate). The folio | wing describe | s how this injury | previ | aura rue emblo | yee from | n resurning to | WORK: | | | | | |
| | | | | | | | | | | | | | | |
| PART III: ACT | IVITY RESTR | RICTIONS' (I | REQUIRED | IF BOX 13(b) IS | CHE | CKED) | | | | | | | | |
| 14. POSTURE | RESTRICTIONS | (If any) : | 17. MC | OTION RESTRICT | CIONS | (if any): | | 19. MISC. RE | STRIC | TIONS (If an | ıy): | | | |
| Max Hours per o | day: 0 2 4 | 6 S Other | Max H | ours per day: 0 | 2 | 4 6 8 Other | • | Max hour | s per d | lay of work:_ | | | | |
| Standing | |] | _ Walkins | g [| | | _ | Sit/Stretc | h break | (s ofpe | r | | | |
| Sitting | | <u> </u> | _ Climbin | arebbahariasa g | | | _ | Must wea | ır splint | /cast at work | t i | | | |
| Kneeling/Squatt | ing 🔲 🗌 |] | Graspir | ng/Squeezing | |] | _ | Must use | crutche | es at ail time: | 5 | | | |
| Bending/Stoopir | 19 🔲 🗆 🖸 | | Wrist fle | exion/extension | | 00 | _ | No driving | g/opera | sting heavy e | quipment | | | |
| . Pushing/Pulling | | | Reachi | na 🗀 | | | _ | = | | utomatic tran | | | | |
| Twisting | | | - J | ad Reaching | | - 677 | - | = ' | _ | | | | | |
| IWISTING | | <u> </u> | - I | · | | | - | ☐ No work | □- | hours/day | work: | | | |
| Other: | <u> </u> | <u> </u> | Keybos | rding | ┙Ш | <u> </u> | - | in ext | reme h | at/cold envir | onments | | | |
| 15. RESTRICTE | ONS SPECIFIC | TO (if applice | ble): Other:_ | | | | | 🔲 authe | ights or | r on scaffoldi | ng | | | |
| L Hand/Write | _ | d/Wrist | | T/CARRY REST | RICTIO | ONS (If any): | | Must kee | P | | | | | |
| L Arm | R Arm | . □ Ne | ock 📗 Ma | y not lift/carry obje | ects m | ore than | bs | ☐ Eleva | ted [| Clean & D | ıry | | | |
| L Leg | R Leg | ☐ Ba | ick for | more thanh | hours | per day | - | No skin c | ontact v | with: | | | | |
| L Foot/Ankle | R Foot | VAnkle | ☐ Ma | y not perform any | lifting/ | carrying | İ | ☐ Dressing | change | s necessary | at work | | | |
| Other: | | | _ □ ঝ | her: | | <u></u> | - | No runnin | g | | | | | |
| 16. OTHER RE | STRICTIONS (I | any): | - | - | | | | 20. MEDICAT | ION RE | ESTRICTION | (S(If any): | | | |
| | | | | | | | _ | Must take | prescri | iption medica | ation(s) | | | |
| | | | | | | | | Advised to | take o | ver-the-cour | nter meds | | | |
| These restrictions a | are based on the d | loctor's best und | erstanding of the | e employee's essenti | lal job (| unctions, if a parti | cular | Medication | n may r | make drowsy | (possible | | | |
| | | | - | at meets these restric | | | - 1 | _ | | | (J-222 | | | |
| ahould be considere | d to be off work. N | iole - th ese r estr | d bluorie anoitoi | e followed outside of | l work e | ıs well as at work. | | safety/driv | ing issu | ues) | | | | |
| PART IV- TRE | ATMENT/EQL | LOWLUD AD | POINTMEN | T INFORMATIO |)N | *** | | | | | | | | |
| 21. Work injury D | | | | ollow-up Service: | | ıde: | | • | | | | | | |
| | _ | IX. | - | the treating doctor | | | | | (date) | at 09:00 am | n_am/pm | | | |
| 692.6 Contact De | rmatitie And Other | | Referral to/Co | | | Q! | <u> </u> | | (date) | | am/pm | | | |
| | | | | cineX per w | eek fo | | | | (date) | _ | am/pm | | | |
| | | 1 | Special studie | • | _ • | an | | (date) | | am/pm | | | | |
| | | | • | the last scheduled | d visit | for this problem | | time, no furthe | | | | | | |
| Date / Time of Viels | EMPLOYEE'S S | | | SIGNATURE | | Visit Type: | Role of C | | | Treating o | | | | |
| 07/07/2009 12:97 pr | | ,, | 1 1 | Δ. e. | | ☑ Initial | Deeig | notoob beleng | | Referrel d | toctor | | | |
| Diacharga Time | I | | 1 / 7/2000 | | | 1 | Cerri | er-selected BMF | | ☐ Cesoulde | a decter | | | |

DIVISION OF WORKERS' COMPENSATION

Follow-up DWC-selected RME

07/07/2009 01:54 pm

Other doctor

| | | • | | | | • | | • | |
|---|---------------------------------------|--|--|-------------------|------------------------|----------------------|---------------------------|---------------|--|
| Send the specified copies to your | | | | | | | | | |
| Workers' Compensation Insurance Carrier | | | | TWCC CLAIM # | | | | | |
| and the injured employee. | | | - | | | | | | |
| *Employers - Do not send this form to the Texas Workers' Compensation Commission, | | | | | | | | | |
| | | | | · . | | | | | |
| unless the Commission specifically requests | | | | CARRIER'S CLAIM # | | | | | |
| a direct filing. | | | | | | | | | |
| | | | <u> </u> | | | | | | |
| i | | EMDI AVEDIC EIDET BE | OODT O | NE IN HURY | 30 II I NE | -ce | | | |
| 1 Name (Last First M.I.) | · · · · · · · · · · · · · · · · · · · | EMPLOYER'S FIRST RE 2. Sex | | 15. Date of l | | 16. Time of Injury | 17. Date Lost | Time | |
| a 1 - | • | □ ғ 👿 м | | 1. | - | ' ' ' | N/A | | |
| Contact . O | | | | 6-25- | | am pm | | | |
| Social Security No. | 4. Home Phone | 5. Date of Birth | 1 | 18. Nature of | | 19. Part of Body In | jured or Expos | ed* | |
| (b) (4) | (D) (4) | (b) (4) | | Rash | | Both A | rm5 | | |
| 6. Does the Employee Spe | ak English? II No | , Specify Language | 1 | | | y/Illness Occurred* | | | |
| Yes No | | | | Allegic Reaction | | | | | |
| 7. Race | 8. Ethnicity | | -{ | L | Ų | ary or Exposure Occ | urred | | |
| Hispanic | | | Name of business if incident occurred on a business site | | | | | | |
| Hispanie | } | | | { | NIA | | - | | |
| ⁹ (b) (4) | | | | City | NA | State | Zip | | |
| City | State | Zia County | - | | | tool, machine, etc.) | * | | |
| City (b) (4) | Diote | Tab Colon i | İ | ZT. Gaage VI | | toor, macrime, etc., | | | |
| 0. Marital Status: | (00/) | | 1 | } | MA | | | 1 | |
| 11. Number of Dependent (| | 12. Spouse's Name | 7 | 25. List Witne | esses: | | | | |
| | | Lisa Perez | | | N/A | | | ļ | |
| 13. Doctor's Name: Se | in T. Dolar | | 1 | 26. Return to | work | 27. Did employee | 28. Super- | 28. Date | |
| Doctor's Mailing Addres | s (Street or P.O.Bo: | x) |] | Date/or e | xpected | die? | visor's name | Reported | |
| Theps 4660 | 10909 E | 6t Fruy | | en San | ne | NO | Savier | 7-7-09 | |
| City | State | Zip . | 1 : | Are D | ay | 100 | Rodriguez | · | |
| Houston | 77 | 77029 | 1 | | | | | | |
| | | | | | | | | | |
| 0. Date of Hire 0) (4) | | hired or recruited in | 32. Lenç | th of Service | | 33. Length of Serv | rice in Occupa | tion | |
| | Texas? | Yes No | (b) (4) | Pr | (mm/yy) SCN+ | (mm/yy) 1/11/05 - | Presen | . | |
| 4. Employee Payroll Class | | | | apation of Inju | ired Worke | er | | | |
| 6. Rate of Pay at this job | 37 Full Work Wee | 1// | | 39. Is employ | ree an Ow | ner, Partner, or Cor | porate Officer | ? | |
| Hourty Weekly | Hours | Days Hours | Days | | | ☐ Yès 🔯 | √n | | |
| 0. Name and Title of Perso | n Completing Form | 100,00 | 41. Nam | e of Business | | | | | |
| Jobe Acos | 1 167 | | CEL | _ | | tal Services | . The | | |
| 2. Business Mailing Addres | s and Telephone N | umber 💋 | 43. Busi | ness Location | (If differe | nt from mailing/add | ess) | | |
| 4904 Chroges R | á. | Tel No: 713-676-1460 | | | | * | | į | |
| Hauston | State | Zip 77021 | City | | State | | Zip | i | |
| Federal Tax Identification 7605929 88 | Number | 45. Primary Standard Indus (SIC) Code* (4 digit) | trial Class | sification | 46. Speci (4 digit) | fic SIC Code* | 47. Texas Co payer No. | mptroller Tax | |
| Workers Compensation | | | 49. Polic | y Number | 1 (- 319-17 | | <u> </u> | | |
| Texas Mi | itual | , | | | 0860 | 744 | | | |
|). Did you request accident | prevention services | | | | | | | | |
| Yes You | If yes, did you re | | ∑ No | E 0/01 | | | | | |
| . Signature and Titl e (RE / | DINSTRUCTIONS | ON INSTRUCTION SHEET | BEFOR | E SIGNING) | 5-1 | 7.0.00 | | | |

You may be soulled to know what information UT Artington (UTA) collects concerning you. You may review and have UTA correct this information according to procedures set forth in UT System BPM #32. The law is found in sections 552.021, 552.-23 and 559.004 of the Texas Government Code.

23 and 559,004 of the Texas Government Code.

Continued on next page

Employee - You are required to report your injury to your employer within 30 days if your employer has workers' compensation insurance. You have the right to free



Trabajador - Es necesario que usted reporte su lesión a su empleador dentro de 30 días a partir del día en que se lesionó, si su empleador tiene seguro de compensación para trabajadores. la Comisión Tejana de Compensación para Trabajadores le ofrece asistencia gratuita, también

assistance from the Texas Workers' Compensation Commission and may be entitled puede que usted tenga derecho a ciertos beneficios médicos y monetarios. Para mayor información llame a la oficina local de la Comisión 1-800-252-7031. to certain medical and income benefits. For further information call your local Commission field office or 1(800)-252-7031. TEXAS WORKERS' COMPENSATION WORK STATUS REPORT (for transmission Date Being Sent 5. Doctor's Name and Degree PART I: GENERAL INFORMATION purposes only) Jean T. Dolan, MD 07/07/2009 1. Injured Employee's Name 6. Clinic/Facility Name 9. Employer's Name Joe A. Gonzales CMC - Houston I-10 East CES Environmental 2. Date of Injury 7. Clinic/Facility/Doctor Phone & Fax 10. Employer's Fax # or Email Address (if known) 06/25/2009 (713)973-7947 (713)973-7943 (713)676-1676 8. Clinic/Facility/Doctor Address (street address) Employee's Description of Injury/Accident Patient states: "patient was at work and has rash on 10909 East Frwy Texas Mutual Insurance Company State 12. Carrier's Fax # or Email Address (if known) Houston 77029 (512)224-3889 PART II: WORK STATUS INFORMATION (FULLY COMPLETE ONE INCLUDING ESTIMATED DATES AND DESCRIPTION IN 13(c) AS APPLICABLE) 13. The injured employee's medical condition resulting from the workers' compensation injury: X (a) will allow the employee to return to work as of 07/07/2009 (date) without restrictions. (b) will allow the employee to return to work as of _ (date) with the restrictions identified in PART III, which are expected to last through ___ (date) and is expected to continue (c) has prevented and still prevents the employee from returning to work as of _(date). The following describes how this injury prevents the employee from returning to work: PART III: ACTIVITY RESTRICTIONS* (REQUIRED IF BOX 13(b) IS CHECKED) 14. POSTURE RESTRICTIONS (if any) : 17. MOTION RESTRICTIONS (if any): 19. MISC. RESTRICTIONS (if any): Max hours per day of work: _ Max Hours per day: 0 2 4 6 8 Other Max Hours per day: 0 2 4 6 8 Other Standing Sit/Stretch breaks of ____per_ Sitting Climbing stairs/ladders Must wear splint/cast at work Kneeling/Squatting Grasping/Squeezing Must use crutches at all times Bending/Stooping Wrist flexion/extension No driving/operating heavy equipment Pushing/Pulling Reaching Can only drive automatic transmission

| L Leg L Foot/Ankle Other: | R Leg Back R Foot/Ankle | for more thanhours per day May not perform any lifting/carrying Other: | No skin contact with: Dressing changes necessary at work No running | |
|-------------------------------|-----------------------------------|---|---|--|
| 16. OTHER RESTRIC | TIONS (if any): | 20. MEDICATION RESTRICTIONS(if any Must take prescription medication(s) Advised to take over-the-counter meds | | |
| estriction does not apply, it | should be disregarded. If modifie | ting of the employee's essential job functions. If a particular d duty that meets these restrictions is not available, the patient should be followed outside of work as well as at work. | Medication may make drowsy (possible safety/driving issues) | |
| | | NTMENT INFORMATION Dected Follow-up Services Include: | | |

18. LIFT/CARRY RESTRICTIONS (if any):

May not lift/carry objects more than ___

Overhead Reaching

Keyboarding

Neck

Contact Dermatitis And Other Eczema Du Referral to/Consult with Evaluation by the treating doctor on 07/13/2009

■ 07/13/2009

■ 07/13/2009

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■ 07/13/2009

■ 0 _ (date) at <u>09:00 am</u> am/pm __ (date) at___ Physical medicine ____X per week for ___weeks starting on ____ _ (date) at_ Special studies (list): ___ _ (date) at_ None. This is the last scheduled visit for this problem. At this time, no further medical care is anticipated Date / Time of Visit **EMPLOYEE'S SIGNATURE** DOCTOR'S SIGNATURE Visit Type: Role of Doctor: Treating doctor 07/07/2009 12:37 pm Designated doctor Referral doctor X Initial Discharge Time ☐ Carrier-selected RME □ Consulting doctor Follow-up 07/07/2009 01:54 pm □ DWC-selected RME Other doctor

DWC FORM-73 (Rev. 10/05) Page 1

Twisting

LAm

L Hand/Wrist

15. RESTRICTIONS SPECIFIC TO (if applicable):

R Arm

R Hand/Wrist

Other:



DIVISION OF WORKERS' COMPENSATION

No work/ ___hours/day work:

at heights or on scaffolding

☐ Elevated ☐ Clean & Dry

Must keep_

in extreme hot/cold environments

Employee - You are required to report your injury to your employer within 30 days if your employer has workers' compensation insurance. You have the right to free assistance from the Texas Workers' Compensation Commission and may be entitled to certain medical and income benefits. For further information call your local Commission field office or 1(800)-252-7031.



Trabajador - Es necesarto que usted reporte su tesión a su empleador dentro de 30 dias a partir del día en que se tesionó, si su empleador tiene seguro de compensación para trabajedores, la Comisión Tejana de Compensación para Trabajadores le ofrece asistencia gratuita, también puede que usted tenga derecho a ciertos beneficios médicos y monetarios. Para mayor información llame a la oficina local de le Comisión 1-800-252-7031.

| TEXAS WORK | LING COMPLINGATION WORK | | |
|--|---|---|-------------------------------|
| PART I: GENERAL INFORMATION | 5. Doctor's Name and Degree Jean T. Dolan, MD | (for transmission purposes only) | Date Being Sent 07/07/2009 |
| 1. Injured Employee's Name | 6. Clinic/Facility Name | 9. Employer's Name | |
| Joe A. Gonzales | CMC - Houston I-10 East | CES Environmental | |
| Date of Injury 3. Social Security Number | 7. Clinic/Facility/Doctor Phone & Fax | 10. Employer's Fax # or Email A | ddress (if known) |
| 06/25/2009 (b) (4) | (713)973-7943 (713)973-7947 | (713)676-1676 | |
| 4. Employee's Description of Injury/Accident | Clinic/Facility/Doctor Address (street address) | 11. Insurance Carrier | |
| Patient states: "patient was at work and has rash on both arms." | 10909 East Frwy | Texas Mutual Insurance Cor | |
| DOLL KILLS | City State Zip | 12. Carrier's Fax # or Email Add | ress (if known) |
| | Houston TX 77029 | (512)224-3889 | |
| PART II: WORK STATUS INFORMATIO | N (FULLY COMPLETE ONE INCLUDING ESTIMATE | D DATES AND DESCRIPTION IN 13(c) | AS APPLICABLE) |
| The injured employee's medical condition in | esulting from the workers' compensation injury: | | |
| (a) will allow the employee to return to w | ork as of 07/07/2009 (date) without restric | tions. | |
| | ork as of(date) with the restric | ctions identified in PART III, wh | nich are |
| expected to last through | | | |
| | nployee from returning to work as of | | |
| trirough(date). The folio | wing describes how this injury prevents the | amployee from returning to work | |
| | | | |
| PART III: ACTIVITY RESTRICTIONS* (| REQUIRED IF BOX 13(b) IS CHECKED) | | |
| 14. POSTURE RESTRICTIONS (if any) : | 17. MOTION RESTRICTIONS (if any): | 19. MISC. RESTRIC | CTIONS (if anv): |
| Max Hours per day: 0 2 4 6 8 Other | · ' ' | l — | day of work: |
| | | | |
| Standing | _ Walking | | ks ofper |
| Sitting UUUU | _ Climbing stairs/ladders | Must wear splin | t/cast at work |
| Kneeling/Squatting | _ Grasping/Squeezing [] [] [] | Must use crutch | ies at all times |
| Bending/Stooping | Wrist flexion/extension | No driving/oper | ating heavy equipment |
| Pushing/Pulling | Reaching | Can only drive a | automatic transmission |
| | | | 1 |
| Twisting | Overhead Reaching | | hours/day work: |
| Other: | Keyboarding | in extreme I | hot/cold environments |
| 15. RESTRICTIONS SPECIFIC TO (if applications) | able): Other: | at heights o | r on scaffolding |
| ☐ L Hand/Wrist ☐ R Hand/Wrist | 18. LIFT/CARRY RESTRICTIONS (if ar | ny): Must keep | |
| | eck May not lift/carry objects more than | lbs | Clean & Drv |
| | ack for more than hours per day | | ─ ´ i |
| | i — | | with: |
| L Foot/Ankle R Foot/Ankle | May not perform any lifting/carrying | Dressing change | es necessary at work |
| Other: | Other: | ——— 🔲 No running | |
| 16. OTHER RESTRICTIONS (if any): | | 20. MEDICATION R | ESTRICTIONS(if any): |
| · · · · · · · · · · · · · · · · · · · | | l <u> </u> | ription medication(s) |
| | | 1 🗎 | |
| | | <u> </u> | over-the-counter meds |
| | rstanding of the employee's essential job functions. If a lodifled duty that meets these restrictions is not available | | make drowsy (possible |
| . , , , , . | ctions should be followed outside of work as well as at t | l satety/driving iss | iues) |
| | | | |
| PART IV: TREATMENT/FOLLOW-UP AF | | <u>,, , , , , , , , , , , , , , , , , , ,</u> | <u>.</u> . |
| | Expected Follow-up Services Include: | | |
| osz.o – Coniaci Dermainis And Other Eczema Du.—. | Evaluation by the treating doctor on 07/13/2009 | | at 09:00 am am/pm |
| I <u></u> - | Referral to/Consult with | on (date) | |
| l— | Physical medicineX per week forweek | | |
| | Special studies (list): None. This is the last scheduled visit for this pr | on (date) | |
| Date / Time of Visit EMPLOYEE'S SIGNATURE | DOCTOR'S SIGNATURE Visit Type | | Treating doctor |
| 07/07/2009 12:37 pm | Initial | ☐ Designated doctor | Referral doctor |
| Discharge Time | i | Carrier-selected RME | Consulting doctor |
| 07/07/2009 01:54 pm | ☐ Follo | w-up DWC-selected RME | Other doctor |

DWC FORM-73 (Rev. 10/05) Page 1



Claim Number:

Concentra Medical Centers

10909 East Frwy Houston, TX 77029 Phone: (713) 973-7943 Fax: (713) 973-7947

Service Date: 07/07/2009 Case Date: 06/25/2009

Physician Activity Status Report

Patient: Gonzales, Joe A. SSN: Address Home: Work: Ext.:

Employer Location: CES Environmental Address:

4904 Griggs Rd

Role:

Contact: Prabhakar Thangudu **DER/Primary**

Houston, TX 770213208

Phone: (281) 433-9792 Ext.:

Auth, by:

Fax:

(713) 676-1676

This Visit: Time In: 12:30 pm

Time Out: 01:54 pm

Recordable: N/A

Visit Type: New

Treating Provider: Jean T. Dolan, MD

Medications:

Diagnosis: 692.6

Contact Dermatitis And Other Eczema Due To Plants (Exce Dispensed Prescription Medication to Patient

☐ Dispensed Over-The-Counter Prescription

☐ Written Prescription given to Patient

Patient Status:

Regular Activity - Returning for follow-up visit

Return to regular duty on 07/07/2009

Remarks:

Employer Notice:

The prescribed activity recommendations are suggested guidelines to assist in the patient's treatment and rehabilitation. Your employee has been informed that the activity prescription is expected to be followed at work and away from work.

Anticipated Date of Maximum Medical Improvement: 07/21/2009 Actual Date of Maximum Medical Improvement:

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Next Visit(s):

Patient Notice: It is essential to your recovery that you keep your scheduled appointments, but should you need to reschedule or cancel your appointment, please contact the clinic. Thank you for your cooperation.

Monday July 13, 2009 11:00 am

Provider/Facility: Jean T. Dolan, MD

Concentra

Date of Service: 07/07/2009 Date of Injury: 06/25/2009

Attn: Prabhakar Thangudu CES Environmental 4904 Griggs Rd Houston, TX 770213208

Dear Prabhakar Thangudu:

Your employee Joe A. Gonzales received treatment for a new work related injury at our CMC - Houston I-10 East clinic on 07/07/2009.

The billings for this injury care will be sent to Texas Mutual Insurance Company. Please help us provide the best care to your injured employee by filing the Employer's First Report of Injury with your carrier, if not already filed. This will ensure timely reporting and management of this workers' compensation claim.

If you have any questions or the above information is incorrect, please call our office or fax any changes to the attention of the Billing Department.

Sincerely,

CMC - Houston I-10 East Central Business Office 800-733-7098 972-458-7678 Claim Number:

Concentra Medical Centers

10909 East Frwy Houston, TX 77029 Phone: (713) 973-7943 Fax: (713) 973-7947

Service Date: 07/07/2009 Case Date: 06/25/2009

Physician Activity Status Report

Patient: Gonzales, Joe A. SSN: XXX-XX-**Address** Home: Work: Ext.:

Employer Location: CES Environmental

4904 Griggs Rd

Role: DER/Primary

Address:

Phone: (281) 433-9792 Ext.:

Houston, TX 770213208 Auth. by:

Fax: (713) 676-1676

Contact: Prabhakar Thangudu

This Visit: Time in: 12:30 pm Time Out: 01:54 pm Recordable: N/A Visit Type: New

Treating Provider: Jean T. Dolan, MD **Medications:**

☐ Dispensed Prescription Medication to Patient Contact Dermatitis And Other Eczema Due To Plants (Exce Diagnosis: 692.6

☐ Dispensed Over-The-Counter Prescription

■ Written Prescription given to Patient

Patient Status:

Regular Activity - Returning for follow-up visit

Return to regular duty on 07/07/2009

Remarks:

Employer Notice:

The prescribed activity recommendations are suggested guidelines to assist in the patient's treatment and rehabilitation. Your employee has been informed that the activity prescription is expected to be followed at work and away from work.

Anticipated Date of Maximum Medical Improvement: 07/21/2009 Actual Date of Maximum Medical Improvement:

Next Visit(s):

It is essential to your recovery that you keep your scheduled appointments, but should you need to reschedule or cancel your appointment, please contact the clinic. Thank you for your cooperation.

Monday July 13, 2009 11:00 am

Provider/Facility: Jean T. Dolan, MD

Advanced Toxicology Network 4900 Outland Center Dr Ste 103 Memphis, TN 381186572 (888) 290-1150

UDS Result Form Result Information

Center:

CMC - Houston I-10 East

Address:

10909 East Frwy

City:

Houston, TX 77029

Attn:

CMC/TX-HOUSTON I-10 EAST

Patient Name: Patient SSN:

Profile:

DRUG SCREEN: 10 PANEL

Reason:

Post Accident

Rejection:

Date Collected: 07/07/2009

Date Reported: 07/08/2009

Date Received: 07/07/2009

Time: 12:55 PM Time: 11:37 PM

Time: 2:43 AM

Creatinine:

Specific Grav:

Specimen ID:

NEGATIVE

CES Environmental

Houston, TX 770213208

Reported

NDOT

Contact Name: Prabhakar Thangudu

Mail Address: 4904 Griggs Rd

Result:

Status:

Sub Acct :

Location:

Screened Summary

Drug Cutoff/GCMS Cutoff/Screen Amphetamine 500 1000 Barbiturates 200 300 200 300 Benzodiazepines 150 300 Benzoyleogonine Carboxy-THC 50 15 Methadone 200 300 Methaqualone 200 300 2000 Opiates 2000 Propoxyphene 200 300 Phencyclidine 25 25

Comment Summary

Comment

Result Summary

Janet Putnam, Lab Director



07/09/2009

C E S ENVIRONMENTAL SERVICES I 4904 GRIGGS RD HOUSTON TX 77021-3208

Notification Confirming Receipt of Claim

Date of Injury:

06/25/2009

Injured Worker:

GONZALES, JOE A

Claim Number: Policy Number:

0001080044

Attached is a copy of the information you reported to Texas Mutual Insurance Company which was used to establish this claim. You may submit additional claim information to Texas Mutual Insurance Company. If you have questions regarding this report of injury please contact us at (800) 859-5995.

If your policy includes our workers' compensation health care network option you are required by law to obtain a second Employee Acknowledgement of Workers' Compensation Network Form signed by the injured worker. Please submit a copy of the signed, second acknowledgement form to Texas Mutual Insurance Company. You can find a copy of the form online at www.texasmutual.com/hcn/shtm

Below please find information that will help you through the claim process:

To submit additional claim information:

Mail to: P. O. Box 12029 Austin, Texas 78711-2029

Fax to: (512) 224-3889

To locate a treating doctor:

www.texasmutual.com/workers/iwADL.shtm

To contact the handling adjuster:

Call: (800) 859-5995

Monday - Friday; 8:00 a.m. - 5:30 p.m.

To obtain a copy of the Employer and Employee Rights and Responsibilities in the

Workers' Compensation System:

www.texasmutual.com/employers/erRights.shtm

To locate a pharmacy, or for pharmacy questions, contact Scripnet

Call: (888) 880-8562 www.scripnet.com To obtain a copy of the Employer and Employee Rights and Responsibilities for the workers' comp health care network:

www.texasmutual.com/hcn/hcn.shtm

Additional Texas Mutual® online services at www.texasmutual.com, available 6 a.m. - 9 p.m., include:

- o Obtain logon id, or for immediate logon id, call (800) 859-5995, M-F, 8:00 a.m. 5:30 p.m.
- o Submit first report of injury in the Employers section
- Submit wage statement when reviewing loss runs and claim details
- o Obtain specific claim summary information



Claim Number:

99K0000575826

Notification Date: 07/09/2009

EMPLOYER'S FIRST REPORT OF INJURY

| INJURED EMPLOYEE | BUSINESS/EMPLOYER |
|--|--|
| Name: JOE A GONZALES SSN: XXX-XX-(b) Mailing Address: (b) (4) | Name: C E S ENVIRONMENTAL SERVICES I Address: 4904 GRIGGS RD HOUSTON TX 77021-3208 |
| County: (b) (4) S Physical Address: (b) (4) County: (b) (4) | Phone: (713)676-1460 Ext: Fax: (713)676-1676 Policy Number: 0001086044 FEIN: 760592985 Location ID: |
| Home Phone: Date of Birth: Marital Status: Married Gender: Male Dependents: 00 Language: English MEDICAL PROVIDER | Ccupation: Hire Date: Partner/Officer/Owner: Date Lost Time Began: Cast Paycheck was: Wage: Frequency: Cocupation: State: TX No 00/00/0000 06/26/2009 06/26/2009 Hourly |
| Name: JEAN T DOLEN Tax ID: Address: 10909 EAST FWY HOUSTON TX 77029 | Frequency: Hourly Hours/Week: Pcriod Start: 00/00/0000 Period End: 00/00/0000 Supervisor Name: JAVIER RODRIGUEZ Phone: Ext: |
| Phone: Fax: ATTORNEY | PREPARER OF REPORT |
| Represented by Attorney: Name: Phone: | Name: JOSE ACOSTA Phone: (713)676-1460 Ext: Fax: Email: |
| INJU | JRY INFORMATION |
| Date of Injury: 06/25/2009 Time: 00:00 Date Reported: 07/07/2009 | Address Where Injury Occurred: TX |
| Nature of Injury: DERMATITIS | |
| Cause of Injury: MISC. CAUSES-ABSORB, INGEST OR INHALATION, NOC | County: Witnesses: Name: Phone: |
| Part of Body: MULTIPLE UPPER EXTREMITIES | Name: Phone: Name: |

Phone:

No

Fatality:

How and Why the Injury/Illness Occurred
RASH BOTH ARMS; "ALLERGIC REACTION" PER DWC1

C E S ENVIRONMENTAL SERVICES I 4904 GRIGGS RD HOUSTON TX 77021-3208

Texas Mutual Insurance Company has redesigned the First Report of Injury (eFROI) section of texasmutual.com. More than 55% of all new reports of injury are submitted through the Texas Mutual Online (TMO) application. The redesign makes the first report of injury services more intuitive and easier for policyholders to use.

Here is an overview of the new features:

- Policyholders will now have the ability to login. By logging in, policy information will pre-fill.
- Customers who login will also have the ability to create profiles with information they always want to pre-fill in a first report of injury (such as supervisor or medical provider information).
- A copy function has been added to automatically populate information that may be the same (such as preparer, contact or address information).
- Certain fields have default values. For example, the state field defaults to Texas for all address fields
- Search functions have been added to make it easier to find the part of body or nature of injury, when reporting a claim.

To use the enhanced online claim reporting tool:

- Go to texasmutual.com
- Click on Report an Injury in the Employer section
- Login with your username and password for policy information to pre-fill, or you have the option to skip login.

To see the redesign, a video is available at the login page. If you are not registered to use Texas Mutual online services, complete the online application at texasmutual.com, or call the Information Services Center at (800) 859-5995.



Employer's Authorization for Examination or Treatment

| (MUST PRESENT PHOTO | O ID AT TIME OF SERVICE) |
|--|--|
| Patient Name: Joe GONzalz | SSN: |
| Company Name: CES Environmento | Services Date of Birth: (b) (4) |
| Location #/Street Address: 4904 Griggs Houston, TX 7 | Pd |
| Temporary Staffing Agency: (713) 676-12 | 160 |
| WORK-RELATEDINJURYILLNE | SS DOT PHYSICAL |
| Post-Accident Substance Abuse Testing: | Preplacement |
| Drug Screen | Recertification |
| Breath Alcohol | Exit |
| Drug Screen and Breath Alcohol | Audiogram |
| Urine Collection Only | Regulated Drug Screen |
| | Urine Collection Only |
| DOT Regulated | Breath Alcohol |
| Non-regulated | |
| PRE-PLACEMENT EVALUATION | SUBSTANCE ABUSE TESTING |
| Job Title: | Regulated |
| Physical Exam | Non-regulated |
| HPE | Urine Collection Only |
| Regulated Drug Screen | Rapid Test |
| Non-regulated Drug Screen | Pre-placement |
| Urine Collection Only | Reasonable Suspicion |
| Hair Collection | Random |
| Audiogram | Periodic |
| | Post-accident |
| | Follow-up |
| SPECIAL PHYSICAL EXAMINATIONS | Breath Alcohol |
| Asbestos | |
| Respirator | BILLING |
| Hazmat | Employee to pay charges at time of service |
| Baseline | Workers' Compensation |
| Other | Insurance Co: |
| | Policy #: |
| | Phone #: |
| Authorized By: Labhulthyd | Title: HSE Managa |
| Phone: 713-676-1460 | Date: 7-7-09 |
| (copies of this form available | at www.concentrahealth.com) |

Jorge Lara 4-7-09

EPAHO042001778

Claim # (b) (4) Torge Lara

Allied Medical Center

Initial WC Evaluation Office: East

| -1/12/2 |
|--|
| PATIENT NAME: LARA, JORGE DATE: //// D |
| SOC. SEC. #: DOE (b) (4) AGE: |
| Insurance Carrier: Network: |
| VITAL STATISTICS PRESENT MEDICAL CONDITION: |
| WT:HT:BP:/ PULSE:RESP:TEMP: |
| WT:HT:BP:PULSE:RESP:TEMP: DOI: |
| PAIN DESCRIPTION: ACHING BURNING SHARP RADIATING NUMBNESS TOGLING |
| AGGRAVATED BY: SITTING STANDING WALKING STAIRS COUGHING BENDING |
| ALLEVIATED BY: |
| HISTORY OF PRESENT ILLNESS |
| The 11/09 defines blady to lest air and so inside a fank with an essence of was on control of tank (ownted what on the of tank to feel able to fathe and lift in septem and out frequency of the feel feel father and old in an anti- a wall - new ord out an another to make the feel of the same and wall of the feel of the |
| HOSPITALIZATION/SURGERIES: |
| PRIOR WORK INJURIES/MVA: MVA - 4/21/09 - Resolved. |
| SOCIAL/FAMILY HISTORY |
| MARITAL STATUS: S M D W # OF CHILDREN: LIVING STATUS: 488 |
| SMOKER: (YES NO ALCOHOL: YES NO SOCIAL HEAVY DRUGUSE: YES NO |

| | | | | A.C. | E | <u>XAM</u> | <u>INAT</u> | <u>ION FO</u> | <u>RM</u> | | ₹C7 | | | | | |
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Send to workers' compensation carrier:

Texas Mutual 713-316-2191

(Name and fax number of carrier)



| CLAIM# 99K000057565302 | _ |
|------------------------|---|
| CARRIER'S CLAIM# | |

☐ Initial ☐ Amended

EMPLOYER'S WAGE STATEMENT

The Texas Workers' Compensation Act and Workers' Compensation rules require an employer to provide an Employer's Wage Statement to its workers' compensation insurance carrier (carrier) and the claimant or the claimant's representative, if any. The purpose of the form is to provide the employee's wage information to the carrier for calculating the employee's Average Weekly Wage (AWW) to establish benefits due to the employee or a beneficiary.

The AWW is based on the wages the employee earned in the 13 weeks immediately preceding the date of injury (or the wage a similar employee earned if the employee did not work the full 13-week period). "Wages" include all forms of remuneration payable to an employee for personal services, including fringe benefits. To simplify filing, employers may file wages in a monthly, biweekly, or weekly manner as discussed below.

NOTE - An employer who fails without good cause to timely file a complete wage statement as required by the Texas Workers' Compensation Act, Texas Labor Code, Section 408.063(c) and Worker's Compensation Rule 120.4 may be assessed an administrative penalty not to exceed \$500.00 for an initial offense and not to exceed \$10,000.00 for a repeated administrative violation.

The employer shall timely file a complete wage statement in the form and manner prescribed by the Division.

- (1) The wage statement shall be filed "filed" means received) with the carrier, the claimant, and the claimant's representative (if any) within 30 days of the earliest of:
 - (A) the employee's eighth day of disability;
 - (B) the date the employer is notified that the employee is entitled to income benefits;
 - (C) the date of the employee's death as a result of a compensable injury.
- (2) The wage statement shall also be filed with the Division within seven days of receiving a request from the Division (Only When Requested).
- (3) A subsequent wage statement shall be filed with the carrier, employee, and the employee's representative (if any) within seven days if any information contained on the previous wage statement changes (such as if the employer discontinues providing a nonpecuniary wage that was initially continued after the date of injury).

All applicable DWC rules can be found at www.tdi.state.tx.us

| Employee's Name (Last, First, M.I.): Care and a proper in the street of P.O. Box): Employee's Mailing Address (Street or P.O. Box): Employee's Mailing Address (Street or P.O. Box): Employee's Mailing Address (Street or P.O. Box): 4904 Griggs Rd City: State: ZIP Code: Houston TX 77021 Social Security Number (last four digits): XXX-X 50 (4) | EMPLOYEE AND EMPLOYER INFO | RMATION | | | | | | | | |
|--|--|---------------------------|---|-----------------------|-------------------------------|--|--|--|--|--|
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| City: State: ZIP Code: | Employee's Mailing Address (Street or P.O. Box): | | | | | | | | | |
| City: State: ZIP Code: | (b) (4) | | 4904 Griggs Rd | | | | | | | |
| Social Security Number (last four digits): XXXXXIII | City: State: | ZIP Code: | | | ZIP Code: | | | | | |
| Date of line: Date of line: | | | | TX | 77021 | | | | | |
| Date of Fire: Date of Injury: T/07/09 Date of Injury: Date of Injury: Dose Acosta | | | | 7 | | | | | | |
| As of today's date, the employee is not back at work. OR and is working: without restriction. OR with restrictions and is earning wages of \$ | | | | | | | | | | |
| As of today's date, the employee is not back at work. OR ☐ The employee returned to work on and is working: ☐ without restriction. OR ☐ with restrictions and is earning wages of \$ per week/month (circle one). NOTE - Rule 120.3 requires the employer file the Supplemental Report of Injury (DWC FORM-6) to report changes in Work Status and Post-Injury Earnings. EMPLOYMENT STATUS AT TIME OF INJURY (Check All That Apply) ☐ Full-time: employee who regularly works at least 30 hours per week and whose schedule is comparable to other employees of the company and/or other employees in the same business or vicinity who are considered full-time. ☐ Part-time: Not Regular Course of Conduct: employee who as regular course of conduct engages in seasonal or cyclical employment that may or may not be agricultural in nature and that does not continue throughout the year. ☐ Apprentice: employee who is learning a skilled trade or art by practical experience under the direction of a skilled crafts person or artisan. I HEREBY CERTIFY THAT this wage statement is complete, accurate, and complies with the Texas Workers' Compensation Act and applicable rules, complete, accurate, and the listed wages include all pecuniary and nonepecuniary and nonepecuniary and replect and the listed wages include all pecuniary and nonepecuniary and representation about a workers' compensation Act and applicable rules, and the listed wages include all pecuniary and nonepecuniary and representation about a workers' compensation Act and applicable rules, and the listed wages include all pecuniary and nonepecuniary and representation and the listed wages include all pecuniary and representation and the listed wages include all pecuniary and nonepecuniary and representation and the listed wages include all pecuniary and representation and the listed wages include all pecuniary and representation and the listed wages include all pecuniary and representation and the listed wages include all pecuniary and representation and the listed wages | · · | • | | son Providing Wage II | nformation: | | | | | |
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| | year. | | | | | | | | | |
| | SAME OR SIMIL AR EMPLOYEES | | <u></u> | , | | | | | | |

SAME OR SIMILAR EMPLOYEE?

The wage information on this form is for:

☑ The Injured Employee OR ☐ A Similar Employee (NOTE – If requested by the Division, the employer shall identify the similar employee whose wages were provided.)

If the employee was not employed for 13 continuous weeks before the date of injury, report the wages of an employee who has training, experience, skills & wages comparable to the injured employee AND who performs exprices/tasks comparable in nature and in number of hours. If no similar employee exists, report the limited available wages earned by the injured employee prior to the injury.

NOTE TO INJURED EMPLOYEE – If you were injured on or after 7/1/02, and had employment with more than one employer on the date of injury, you can provide your insurance carrier with wage information from your other employment for the carrier to include in your AWW and this may affect your benefits. Contact your carrier for additional information or call the Division at (800) 252-7031. You can also read rule 122.5 at www.tdi.state.tx.us.

| WAGE INFORMATION INSTRUCTIONS | Employee Name Lara, Jorge | VVV_VV_6/1/38 = | te of Injury: 7/07/09 |
|-------------------------------|---------------------------|-----------------|-----------------------|
| MAGE IN CHIEF TON MOTHER | Laia, Joige | XXX-XX-0000 | 1701708 |

- The employer shall report all wages earned in the 13 weeks immediately preceding the date of injury. If the employee is paid on a monthly or semi-monthly basis, the employer may provide wages for the 3 months preceding the date of injury. Monthly wages may also be converted to weekly wages by dividing the gross monthly amount by 4.34821. If the employee is paid on a biweekly basis, the employer may provide the wages for the 14 weeks preceding the date of injury. When setting the periods to report, the employer may adjust the reporting period backward slightly (up to six days) to line up the reporting timeframes with the employer's natural pay cycle. However, the employer shall not report wages earned on or after the date of injury.
- If reporting weekly earnings, use all 13 Period Columns below. If reporting 3 months of earnings, either convert the wages to weekly earnings or use the first 3 Period Columns. In all cases, indicate the dates that each period covers.

| PECUNIARY WAGE I | NFORM | ATION | | hourly, we commission commission use of the | Pecuniary Wages include all wages that are paid to the employee in the form of money. These include, but are not limite hourly, weekly, biweekly, monthly, etc. wages; salary; tips/gratuities; piecework compensation; monetary allowances; bonuses; commissions. Earnings are reported in the periods they are earned, NOT when they are paid and some (such as bonuses commissions) need to be prorated. Pecuniary wages don't include payments made by an employer to reimburse the employee fo use of the employee's equipment or for paying helpers or to reimburse for travel expenses. Consider as earnings amounts from holidays and any vacation, personal or sick leave an employee used but not the market value of leave time earned but not used. | | | | | | | | | |
|--|---------|-------|-------|--|---|-------|-------|-------|-------|-------|-------|-------|-------|--------|
| PERIOD # (Week #, Month #, or Bi-Week #) | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | |
| FROM DATE: | 4/05 | 4/12 | 4/19 | 4/26 | 5/03 | 5/10 | 5/17 | 5/24 | 5/31 | 6/07 | 6/14 | 6/21 | 6/28 | |
| TO DATE: | 4/11 | 4/18 | 4/25 | 5/02 | 5/09 | 5/16 | 5/23 | 5/30 | 6/06_ | 6/13 | 6/0 | 6/27 | 7/04 | TOTALS |
| # HOURS WORKED: | 44.16 | 48.32 | 35.28 | 52.34 | 44.14 | 49.25 | 44.24 | 49.25 | 49.08 | 52.28 | 51.19 | 49.32 | 55.20 | 624.05 |
| GROSS WAGES EARNED: | (b) (4) | | | | | | | | | | | | | |

| NONPECUN | NIARY | WAGE | | | | benefits | onpecuniary Wages include all wages paid to the employee in a form other than money. These include, but are not limited to, the enefits listed below but do not include monetary allowances or stipends paid to allow the employee to purchase the benefits. | | | | | | | | | | | |
|---------------------------|----------|----------------------------|---------|----------|----------|----------|--|---|---|---|---|----|----|----|------|--------|----------------------------|---|
| Nonpecuniary Wage Type | Provide | loyer ed Prior jury? | Spe | cify Val | ue Or An | nount Ea | (Use the same periods as used above) | | | | | | | | | Contir | nployer nue To ride? | Date Benefit Suspended (if suspended) |
| | YES | NO | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 ~ | YES | NO | |
| Health Insurance | V | | (b) (4) | | | | | | | | | | | | | | V | 7/31/09 |
| Laundry/ Cleaning | MA | | | | | | | | | | | | | | | | | |
| Clothing/ Uniforms | # | | | | | | | | | | | | | | | | | |
| Lodging/ Housing/ | NB | | | | | | | | | | | | | | | | | |
| Food/ Meals | ALA | | | | | | | | | | | | | | | | | |
| Vehicle/ Fuel | 4/7 | | | | | | | | | | | | | | | | | |
| Other | AL | | | | | | | | | | | | | | | | | |



7/13/2009 8:58

Employee Timecard Report

^ Adjusted Value

< Previous Pay Period Punch { Previous Day Punch

CES Environmental Services, Inc. 7/5/2009 - 7/11/2009

? Exception

+ Added Item

* Tardy

~ Holiday Punch

Badge: 112 ID:0086

HTO - Hours Toward Weekly Overtime

Lara, Jorge (Tankwash)

| | • | | | | | | | - | |
|-------------------|----------|-----------|------------|---------|------------|------------|-------|-----------------|------|
| Date | ln | Out | In | Out | Total | Overtime | HTO A | proved By | Note |
| 7/5/2009 Sun | None | | | • | 0:00 | 0:00 | 0:00 | 0:00 | |
| 7/6/2009 Mon | 13:53 | 20:43 | 21:09 | 0:06 | 9:47 | 0:00 | 9:47 | 0:00 | |
| 7/7/2009 Tue | 13:56 მვ | DP 11:42 | | | 21:46 | 0:00 | 31:33 | 0:00 | |
| 7/8/2009 Wed | 18:31 | 14:04 | | | 19:33 | 11:06 | 51:06 | 0:00 | |
| 7/9/2009 Thu | 20:42 | 21:36 | 23:17 | . 13:39 | 15:16 | 15:16 | 66:22 | 0:00 | |
| 7/10/2009 Fri | None | 157 | | | 0:00 | 0:00 | 66:22 | 0:00 | |
| 7/11/2009 Sat | 9:25 | 12:18 | | | 2:53 | 2:53 | 69:15 | 0:00 | |
| <u>Department</u> | Reg | <u>ot</u> | <u>Vac</u> | Sick | <u>Hoi</u> | <u>Per</u> | Other | <u>Total</u> | |
| Tankwash | 40:00 | 29:15 | 0:00 | 0:00 | 0:00 | 0:00 | 0:00 | 69:15 | |
| Totals | 40:00 | 29:15 | 0:00 | 0:00 | 0:00 | 0:00 | 0:00 | _69:15 45:13 | |
| | | 5:13 | | | _ | | | 45:13 | 1 |
| | | | | |) | | | | |

45:13

Date

Employee Signature

Approved By

Notes:

None Listed

<u>Text</u>

Date Editor

FR: 13:39 - 1900- 1930-

Page 43

Employee - You are required to report your injury to your employer partial 30 days if your employer has workers' compensation insurance. You have the right assistance from the Teras Department of Insurance, Division of Workers' Compensation. I may be entitled to certain medical and income benefits. For further information call your local Division field office or (800)-252-7031.



Empleado - Es necesario que resporte su lesión a su empleador dentro de 30 dias a partir de la fecha en que se lesionó si es que su empleador de compensación para trabajadorea. Usted tiene derecho a recibir asistencia.

a por parte de la División de Compensación para Trabajadorea, y también puede tener derecho a ucircos beneficios médicos y monetarios. Para mayor información comuniquese con la oficina local de la División al teléfono 1-800-252-7031.

| 2. TEXAS WORKERS' COMPENSA | TION WORK STATUS REPORT | |
|--|--|--|
| PART I: GENERAL INFORMATION | Poctor's Name and Degree Adult M.D. | (for transmission purposes only) Date Being Sent 1/20/05 |
| 1. Injured Employee's Name 6. LARA, JORGE | Allied Medical Center | 9. Employer's Name CES ENVIROMENTAL |
| 2. Date of Injury 3. Social Security Number 7 | Clinic/Facility/Doctor Phone & Fax (713) 450-2838(713) 450-2843 | 10. Employer's Fax # or Email Address (if known) (713) 676-1676 |
| 4. Employee's Description of Injustic cident 1. 8. TWO WEA MA WOLL | Clinic/Facility/Doctor Address (street address) 11430 I- 10 East Frwy., Ste 350 | 11. Insurance Carrier Mutual |
| Explosion. | ty State Zip Houston TX, 77029 | 12. Carrier's Fax # or Email Address (if known) 512 - 224 - 3889 |
| DART II. MORK STATUS INCORMATION (CIT | LIVORNO ETE QUE MALVONO ESTAVEZA DATE | |
| PART II: WORK STATUS INFORMATION (FUI | | es and description in 13(c) as applicable) |
| (a) will allow the employee to return to work | | |
| (de) will allow the employee to return to work | as of (date) with the restrictions is | dentified in PART III, which are |
| expected to last through (date). (c) has prevented and still prevents the empl | ovee from returning to work as of 200 | daxe) and is expected to continue |
| through (M.D.Sdate). The following desc | ribes how this injury prevents the employee fr | om returning to work: |
| DART HE ACTIVITY DESTRICTIONS (ONLY | AND THE ROLL AND A CHECKED | |
| PART III: ACTIVITY RESTRICTIONS* (ONLY 14. POSTURE RESTRICTIONS (if any): | 17. MOTION RESTRICTIONS (if any): | 19. MISC, RESTRICTIONS (If any): |
| Max Hours per day: 0 2 4 6 8 Other | Max Hours per day: 0 2 4 6 8 Other | ☐ Max hours per day of work: |
| Standing | Walking | ☐ Sit/Stretch breaks of per |
| Sitting | Climb stairs/ladders | ☐ Must wear splint/cast at work |
| Kneeling/Squatting | Grasp/Squeeze | ☐ Must use crutches at all times |
| Bending/Stooping 🗆 🗆 🗆 🗆 💮 | Wrist flex/extension 🗆 🔲 🗎 🗎 | ☐ No driving/operating heavy equipment |
| Pushing/Pulling | Reaching | Can only drive automatic transmission |
| Twisting | Overhead Reaching | ☐ Ne Work / ☐ ——hours/day work: |
| Other: | Keyboarding | in extreme hot/cold environments |
| 15. RESTRICTIONS SPECIFIC TO (if applicable): | Other: | at heights or on scaffolding |
| ☐ L Hand/Wrist ☐ R Hand/Wrist | 18. LIFT/CARRY RESTRICTIONS (if any): | ☐ Must keep: |
| LArm RArm Neck | May not lift/carry objects more thanlb | _ |
| ☐ LLeg ☐ RLeg ☐ Back | for more thanhours per day | ☐ No skin contact with: |
| ☐ L Foot/Ankle ☐ R Foot/Ankle | ☐ May not perform any lifting/carrying ☐ Other: | ☐ Dressing changes necessary at work |
| 16. OTHER RESTRICTIONS (if any): | Other. | _ |
| | | ☐ Must take prescription medication(s) |
| | | Advised to take over-the-counter meds |
| * These restrictions are based on the doctor's best under particular restriction does not apply, it should be disregard | | |
| available, the patient should be considered to be off work. No | | |
| | | |
| PART IV: TREATMENT/FOLLOW-UP APPOI | | |
| | pected Follow-up Services Include: | els (date) at: _am/pm |
| The second secon | ferral to/Consult with | on (date) at : am/pm |
| | ysical medicine X per week forweeks star | ································ |
| | ecial studies (list): <u>MHE 7MAS</u> | on (date) at :am/pm |
| | | m. At this time, no further medical care is anticipated. |
| Date / Time of Visit CAMPLOYEE'S SIGNATURE | | It Type: Role of Doctor: Treating doctor |
| Discharge Time Speed | اسرد | Latinus La Designated doctor La Retenda doctor |
| 1 Jane | | ☐ Carrier-selected RME ☐ Consulting doctor |
| | | ☐ TWCC-selected RME ☐ Other doctor |

Time colds
For

7-5/7-11
for all 3 contryes
Fax #

Employee Timecard Report

CES Environmental Services, Inc

? Exception

* Tardy

+ Added Item

^ Adjusted Value 7/12/2009 - 7/18/2009 < Previous Pay Period Punch { Previous Day Punch

HTO - Hours Toward Weekly Overtime

~ Holiday Punch Badge: 112 ID:0086

| | | | HIO - Hours | roward weekly | Overtime | | | ~ Holiday P | unch |
|--------------------------------|----------------|-------------|---------------------------|-------------------------|------------|--|--------------|-----------------|------|
| Lara, Jorge (Ta | ankwash) | - | | | | en an en en en en en en en en en en en en en | | Badge: 112 ID: | 0086 |
| Date | in | Out | ln | Out | Total | Overtime | HTO A | proved By | otes |
| 7/12/2009 Sun | None | | . | | 0:00 | 0:00 | 0:00 | 0:00 | |
| 7/13/2009 Mon | None | | | | 0:00 | 0:00 | 0:00 | 0:00 | |
| 7/14/2009 Tue | None | | | | 0:00 | 0:00 | 0:00 | 0:00 | |
| 7/15/2009 Wed | 13:40 | 21:23 | 22:00 | 23:02 | 8:45 | 0:00 | 8:45 | 0:00 | |
| 7/16/2009 Thu | 7:00 | 8:33 | 13:34 | 23:01 | 11:00 | 0:00 | 19:45 | 0:00 | |
| 7/17/2009 Fri | 13:56 | ? | | | ? | ? | ?19:45 | 0:00 | |
| 7/18/2009 Sat | None | | | | 0:00 | 0:00 | ?19:45 | 0:00 | |
| <u>Department</u> | Reg | <u> </u> | <u>Vac</u> | <u>Sick</u> | <u>Hol</u> | <u>Per</u> | <u>Other</u> | <u>Total</u> | |
| Tankwash | ?19:45 | ?0:00 | ?0:00 | ?0:00 | ?0:00 | ?0:00 | ?0:00 | ?19:45 | |
| Totals | 219:45 2819 | 70:00 | ?0:00 | 70:00 819 + 18 hu | ?0:00 | 70:00 | ?0:00 | 219:45 28 19 | |
| Employee Signature Approved By | ours | 3_ | | Date Date | * /a | 109 | | | |
| Notes: Date None Listed | <u>Editor</u> | <u>Text</u> | ļ. | | | | | | |

MON. UAC.

Fri. 13:56 - 17:00 - 17:30 -



07/22/2009

C E S ENVIRONMENTAL SERVICES I 4904 GRIGGS RD HOUSTON TX 77021-3208 jacosta@cesenvironmental.com

Notification Confirming Receipt of Claim

Date of Injury: Injured Worker

Injured Worker: Claim Number:

Policy Number:

07/07/2009

LARA, JORGE LUIS

(b) (4) 0001086044

Attached is a copy of the information you reported to Texas Mutual Insurance Company which was used to establish this claim. You may submit additional claim information to Texas Mutual Insurance Company. If you have questions regarding this report of injury please contact us at (800) 859-5995.

If your policy includes our workers' compensation health care network option you are required by law to obtain a second Employee Acknowledgement of Workers' Compensation Network Form signed by the injured worker. Please submit a copy of the signed, second acknowledgement form to Texas Mutual Insurance Company. You can find a copy of the form online at www.texasmutual.com/hcn/hcn.shtm

Below please find information that will help you through the claim process:

To submit additional claim information:

Mail to: P. O. Box 12029 Austin, Texas 78711-2029 Fax to: (512) 224-3889 To locate a treating doctor:

www.texasmutual.com/workers/iwADL.shtm

To contact the handling adjuster:

Call: (800) 859-5995

Monday - Friday; 8:00 a.m. - 5:30 p.m.

To obtain a copy of the Employer and Employee Rights and Responsibilities in the Workers' Compensation System:

www.texasmutual.com/employers/erRights.shtm

To locate a pharmacy, or for pharmacy questions, contact Scripnet:

Call: (888) 880-8562 www.scripnet.com To obtain a copy of the Employer and Employee Rights and Responsibilities for the workers' comp health care network:

www.texasmutual.com/hcn/hcn.shtm

Additional Texas Mutual® online services at www.texasmutual.com, available 6 a.m. - 9 p.m., include:

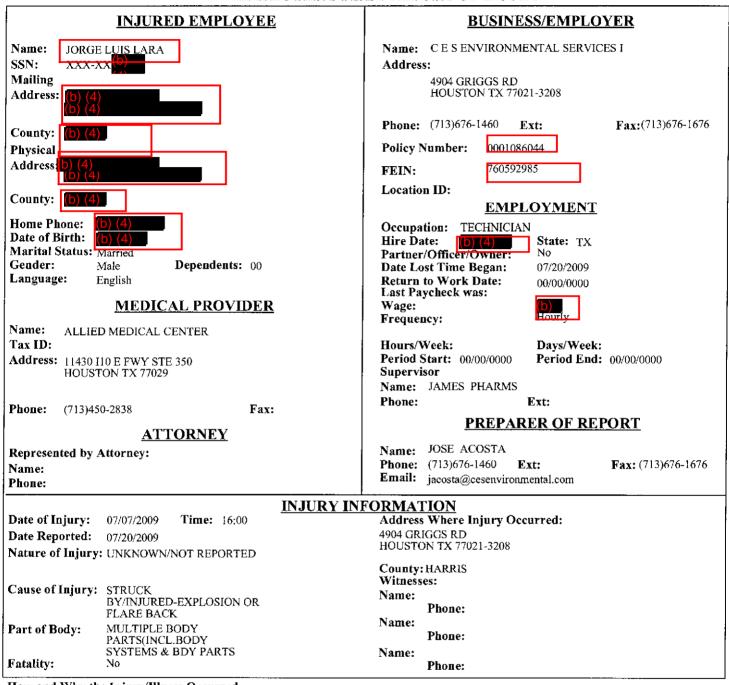
- o Obtain logon id, or for immediate logon id, call (800) 859-5995, M-F, 8:00 a.m. 5:30 p.m.
- o Submit first report of injury in the Employers section
- o Subinit wage statement when reviewing loss runs and claim details
- o Obtain specific claim summary information



Claim Number: 99K000057565302

Notification Date: 07/22/2009

EMPLOYER'S FIRST REPORT OF INJURY



How and Why the Injury/Illness Occurred

LOWER BACK. CHEST. LT THUMB. LT SHOULDER. HE HEARD EXPLOSION AND RAN INTO A WALL RAN INTO A GROUND CABLE.

| TREATMENT PLAN: XR- C/spine, APOM/AP5/LaVFk/Ext. 2 vw: shoulde. 2 vw: knee / ankle / kott. 2 vw: knee / ankle / knee Wrist/hand 2 Foot/ Ankle 2 kmeh | Patier | t: LARA, JORGE |
|--|---------------|--|
| Clypine AP/Lat. Clypine Clypin | TREAT | MENT PLAN: |
| Lispine. AP/Lat/Flx/Ext. Siz vwv. knee / ankle / too Recurrence | | |
| RR Digitization Clespine Clespine Clespine Clespine Clespine Tyspine Tyspine Clespine | L/spine, AP/Lat/Flx/Ext, 92 vw: knee / ankle / foot. |
| C/spine T/spine 70) | TXR Digitization Cless & Reuly |
| Pain Management Specialist: Bebayvioral Medicine Council: CMHE Metal Health Evaluation (IT) Individual Therapy EMG of the: Upper extremities. Lower extremities. Orthopedic evaluation of the: C/spine C/spine L/spine Shoulder Knee Wrist/hand Foot/ Ankle Impairment Rating: STAT/CLINICAL OTHER: FCE referral: BASE LINE WH or CPMP PROGRAM RTN TO WORK Other: Return to Work Programs: Work Hardening 2 weeks 4 weeks 6 weeks Work Conditioning 2 weeks 4 weeks 6 weeks Chronic Pain Management Program 2 weeks 4 weeks 6 weeks Chronic Pain Management Program 2 weeks 4 weeks 6 weeks Requested CPT Code for approval: 7 # weeks PHYSICAL MEDICINE AND REHABILITATION 2 POLLO 9 PO | | C/spine □ T/spine □ Shoulder □ Knee □ Wrist/hand □ Foot/ Ankle |
| Behavioral Medicine Council: A (MHE) Metal Health Evaluation (IT) Individual Therapy EMG of the: Upper extremities. Lower extremities. Orthopedic evaluation of the: C/spine L/spine Shoulder Knee Wrist/hand Foot/ Ankle Impairment Rating: STAT/CLINICAL OTHER: FCE referral: BASE LINE WH or CPMP PROGRAM RTN TO WORK Other: Work Programs: Work Hardening 2 weeks 4 weeks 6 weeks Work Conditioning 2 weeks 4 weeks 6 weeks Chronic Pain Management Program 2 weeks 4 weeks 6 weeks Aquatic Therapy Department: Requested CPT Code for approval: 97113 TX Frequency: Times per week for # weeks Additional Body parts: Refer to: OT PT TX Frequency: Times per week for # weeks MEDICAL NECESSITY: The purpose for the above treatment is to: | | CT scan: Head C/spine T/spine L/spine L/spine L |
| EMG of the: □ Upper extremities. | | Pain Management Specialist: |
| EMG of the: Upper extremities. | $ \emptyset $ | Behavioral Medicine Council: MACMHE) Metal Health Evaluation (IT) Individual Therapy |
| C/spine L/spine Shoulder Knee Wrist/hand Foot/ Ankle Impairment Rating: STAT/CLINICAL OTHER: FCE referral: BASE LINE WH or CPMP PROGRAM RTN TO WORK Other: Return to Work Programs: Work Hardening 2 weeks 4weeks 6weeks Work Chronic Pain Management Program 2 weeks 4weeks 6weeks Chronic Pain Management Program 2 weeks 4weeks 6weeks Aquatic Therapy Department: Requested CPT Code for approval: 97113 TX Frequency: Times per week for # weeks PHYSICAL MEDICINE AND REHABILITATION CARequested CPT Code for approval: 97110 97112 97112 97114 971 | \psi / | |
| FCE referral: _BASE LINE _WH or CPMP PROGRAM _RTN TO WORK Other: | | |
| Other: Return to Work Programs: Work Hardening 2 weeks 4weeks 6weeks Chronic Pain Management Program 2 weeks 4weeks 6weeks Requested CPT Code for approval: 97113 TX Frequency: Times per week for # weeks PHYSICAL MEDICINE AND REHABILITATION Requested CPT Code for approval: 97112 97112 97110 Requested CPT Code for approval: 97112 97110 97012 97110 TX Frequency: Times per week for # weeks Additional Body parts: TX Frequency: Times per week for # weeks MEDICAL NECESSITY: The purpose for the above treatment is to: | | Impairment Rating: STAT/CLINICAL OTHER: |
| Return to Work Programs: Work Hardening _ 2 weeks _ 4weeks _ 6weeks Work Conditioning _ 2 weeks _ 4weeks _ 6weeks Chronic Pain Management Program _ 2 weeks _ 4weeks _ 6weeks Aquatic Therapy Department: Requested CPT Code for approval: 97113 TX Frequency:Times per week for# weeks PHYSICAL MEDICINE AND REHABILITATION CRequested CPT Code for approval: 97112 97110 97110 TX Frequency:Times per week for _ # weeks Additional Body parts: Refer to:OTPT TX Frequency:Times per week for _ # weeks MEDICAL NECESSITY: The purpose for the above treatment is to: | u 1 | FCE referral:BASE LINEWH or CPMP PROGRAMRTN TO WORK |
| Work Hardening 2 weeks 4weeks 6weeks Work Conditioning 2 weeks 4weeks 6weeks Chronic Pain Management Program 2 weeks 4weeks 6weeks Aquatic Therapy Department: Requested CPT Code for approval: 97113 TX Frequency:Times per week for# weeks PHYSICAL MEDICINE AND REHABILITATION CRequested CPT Code for approval: Y// D 971/2 971/40 970/2 971/6 YX Frequency:Times per week for _# weeks Additional Body parts: Refer to:OTPT TX Frequency:Times per week for# weeks MEDICAL NECESSITY: The purpose for the above treatment is to: | | Other: |
| Aquatic Therapy Department: Requested CPT Code for approval: 97113 TX Frequency:Times per week for# weeks PHYSICAL MEDICINE AND REHABILITATION Requested CPT Code for approval: | | ☐ Work Hardening 2 weeks 4weeks 6weeks |
| Requested CPT Code for approval: 97113 TX Frequency:Times per week for# weeks PHYSICAL MEDICINE AND REHABILITATION Requested CPT Code for approval: 9710 97112 97110 9700 97110 TX Frequency:Times per week for# weeks Additional Body parts: | | |
| PHYSICAL MEDICINE AND REHABILITATION O'Requested CPT Code for approval: O'TX Frequency: Times per week for # weeks Additional Body parts: Times per week for # weeks Additional Body parts: Times per week for # weeks MEDICAL NECESSITY: The purpose for the above treatment is to: | | |
| Requested CPT Code for approval: 940 97112 97140 97012 97116 TX Frequency: Times per week for # weeks Additional Body parts: Refer to: PT TX Frequency: Times per week for # weeks MEDICAL NECESSITY: The purpose for the above treatment is to: | | |
| Times per week for # weeks Additional Body parts: Refer to: PT TX Frequency: Times per week for # weeks MEDICAL NECESSITY: The purpose for the above treatment is to: | \$ | |
| Additional Body parts: Refer to: PT TX Frequency: Times per week for # weeks MEDICAL NECESSITY: The purpose for the above treatment is to: | | Correquested CPT Code for approval: 440 97112 97140 9702 97116 |
| TX Frequency:Times per week for# weeks MEDICAL NECESSITY: The purpose for the above treatment is to: | ! | Additional Body parts: Refer to: OT PT |
| \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ | | |
| \(\tag{2} \) | MEDIC | AL NECESSITY: The purpose for the above treatment is to: |
| Increase ROM Increase Tolerance Decrease Swelling Decrease Pain Stabilization Other; | <i>ş</i> | / = 4 |
| Notes: EBP sings 2 whs. Cop strength, Douglar Thoughts | Notes: | Heart Topp, Logs CTABLE. Cop strengths the Double Frengths |
| Tougation of Contact Sque Tendences | 100 | epalm of Combar Sque Tendences And deed rober of 164 RAMA John DIR: |
| TI OI V VOI A | Doctor's | Signature: Date: 7/20/09 |
| | Doctor's | Signature: Date: 1/20107 |



| CLAIM# | 99K0000 675 65302 |
|----------|-------------------|
| Carrier# | |
| | |

SUPPLEMENTAL REPORT OF INJURY

| Part I EMPLOYER INFORMATION | J | | | |
|--|---|--|---------------------------------|--------------------------------|
| Employer business name | | | Employer phor | |
| CES Environmental Services | ; | | 713-676-14 | 160 |
| Employer mailing address | | | | |
| 4904 Griggs Rd | | | | |
| Insurance carrier name | | | | |
| Texas Mutual | | | | |
| 5. Does the employer have return to work of the so, identify contact person a | | based on the injured work | er's current capabilit | ies? yes no |
| Has the insurance carrier provided RTW | coordination services within the | he past 12 months? yes | Date | no 🗸 |
| 7. Has the employer requested RTW training | g from DWC or the insurance | carrier? yes [| | no 📝 |
| 8. Has the insurance carrier provided accid- | ent prevention services in the | past 12 months? yes | Date | no ✓ |
| Has the employer requested accident pre | evention services from the inst | urance carrier? yes [| | no |
| Part II REASON FOR FILING THIS | REPORT (deadlines | vary, see instruction | s) | |
| 10. a. The injured worker returned | | | | |
| b. The injured worker is earning | | | · | davs. |
| | then later had additional lost t | • = | • | |
| d. The injured worker resigned | | - | · - | The William C days. |
| Part III INJURED WORKER INFOI | | | - | |
| 11. Injured worker name | MINITON | 12. SSN (last 4 digits) | | 13. DOI |
| Jorge Lara | | (b) (4) | | 7/7/2009 |
| 14 Injured worker mailing address and phor | <u> e#</u> | <u></u> , | | |
| (b) | İ | 1 | | |
| First day of lost time or reduced wages for this injury (mm/dd/yyyy) | | 16. First day of additiona or reduced wages (n | | |
| 17, Has the injured worker experienced 8 da | ys (cumulative) of lost time or | reduced wages as a result | t of the injury? | yes 🔲 no 🔽 |
| If yes, the date of the 8 th day (mm/dd/yyy | y) | | | |
| 18. Date of most recent RTW | 19. Has the injured worker | resigned, been terminated | or died? | yes 🗸 no 🦳 |
| Full duty, full pay | date of resignation | date of termination | n <u>7/22/2009</u> d | ate of death |
| Limited duty, full pay | 19a. Reason for resignation | /termination | | |
| Limited duty, reduced pay | laid off 19b. Was the injured worker | r on limited duty when term | inated? | yes no 🗸 |
| 20. Hours the injured worker was working du | | 21. Weekly/hourly earning | | d of 7-6/09 |
| 7/5/09 to 7/11/09: 4 | 5.08 hours per week | to 7/11/09:5- | veekly | (b) (4) |
| | O _e O C Hours per week | | Veckiy | |
| Indicated hours are: | | Indicated wages are: | | |
| Increase from pre-injury | | | om pre-injury wage | |
| Same as pre-injury | | | e-injury wage | |
| Decrease from pre-injury | | | from pre-injury wage | |
| This form to be filed with: The employ | er's insurance carrier and t | he injured worker in the t | imeframe as noted | in Part II. |
| 22. To the best of my knowledge the inform | ation provided in this report is | accurate and may be relied | d upon for evaluation | on of eligibility for benefite |
| | | Vorker (<i>If no longer working</i> | | |
| | inproyor injurou (| torker (ii no longer noming | , rev and complete an | nore injury occurred. |
| A Kint HIT M | | | 7- 14-09 | |
| Signature and Title of person completing this for | orm o | Date | 1 1 0 | |
| | | = - 1 -2 | | |
| | | | | |
| | | | | |
| | | | | |

DWC FORM-6 (Rev. 10/05) Page J

DWC FORM-6 Supplemental Report of Injury

DWC requires the reporting of all Return to Work and Post-Injury Change of Earnings. An injured worker is entitled to temporary income benefits if be/she has disability (defined as the inability to work, or the inability to earn wages equivalent to pre-injury wages, as a result of the injury) and has not reached maximum medical improvement (defined as having reached 104 weeks from the eighth day of lost time or when a doctor certifies that no further recovery can be reasonably anticipated). The insurance carrier shall adjust the weekly amount of temporary income benefits paid to the injured worker to match the fluctuations in weekly earnings after the injury. To ensure the insurance carrier has accurate information to calculate benefits, the DWC FORM-6 is to be completed as applicable:

| By EMPLOYER | By INJURED WORKER | | | | | |
|--|---|--|--|--|--|--|
| The EMPLOYER means the employer for whom the injured worker was working when the injury occurred. If the employer is the current employer, then you are responsible to provide information to the workers' compensation insurance carrier about: The existence of earnings, and The amount of any earnings, or Any offers of employment. Include CLAIM and insurance carrier numbers in right upper hand corner. Complete items 1-21, sign and date. | If you (the INJURED WORKER) are no longer employed by the employer where the injury/illness occurred, then you are responsible to provide information to the workers' compensation insurance carrier about: The existence of earnings, and The amount of any earnings, or Any offers of employment. This form may be used to do so. Include CLAIM and insurance carrier numbers in right upper hand corner. Complete items 1-4, 10-21, sign and date. | | | | | |
| The EMPLOYER must file this form: For a worker's injury/illness that occurs after January 1, 1991 and required the previous filing of a DWC FORM-1, Employer's First Report of Injury; and During the time the injured worker is entitled to temporary income henefits (TIBs); and Until the injured worker: Reaches maximum medical improvement (MMI), or Is no longer employed by the employer. | You are receiving benefits, you must tell the insurance carrier if your wages change, regardless of whether your income went up or down; or You are not receiving benefits, you must tell the insurance carrier if the injury causes you to miss work or lose income. | | | | | |

his report must be filed in the following situations within the timeframes indicated:

- 3 days after the injured worker begins to lose time from work as a result of the injury, if lost time did not occur immediately following the injury;
- 3 days after the injured worker returns to work;
- 3 days, when the injured worker returned to work, then later has additional day(s) of lost time as a result of the injury;
- 10 days after the end of each pay period in which the injured worker has a change in earnings as a result of the injury;
- 10 days after the injured worker resigns or is terminated.

While most of the sections on this form are self-explanatory, please note that the pay periods requested in sections 20 & 21 may be different depending on the situation for which the form is being filed:

- If the report is indicating lost time from work or the end of employment, the pay period shall be the most recent pay period prior to the lost time.
- If the report is indicating return to work or a change in earnings, the pay period shall be the pay period the injured worker is beginning.

This form is to be filed by first class mail or personal delivery with:

- · The insurance carrier, and
- · The injured worker.

This report is considered filed when personally delivered or postmarked.

This form is to be filed by first class mail or personal delivery with:

• The insurance carrier.

This report is considered filed when personally delivered or postmarked.

If you return to work for the same employer or a different employer, your temporary income benefits from the insurance carrier must be adjusted.

Failure to report carned wages and/or offers of employment to the insurance carrier who is paying benefits to you is a crime that may result in fines and/or imprisonment.

Failure to comply with these filing requirements, without good cause, is a Class D administrative violation, subject to a penalty not to exceed \$500.

TLC§ 409.005 and Rules 120.3 and 129.4 provide the requirements regarding use of this report. The complete rule text is available on the DWC website at: www.tdi.state.tx.us



DWC FORM-6 (Rev. 10/05) Page 2

Employee - You are required to report your injury to your employer within 30 days if your employer has workers' compensation insurance. You have the right to free assistance from the Texas Department of Insurance, Division of Workers' Compensation and may be entitled to certain modical and income benefits. For further information call your local Division field office or 1(800)-252-7031.



Empleado - Es necesario que reporte su lesión a su empleador dentro de 30 días a partir de la fecha en que se lesionó si es que su empleador enente con un seguro de compensación para trabajadores. Usted tiena derecho a recibir asistencia gratuita per parte de la División de Compensación para Trabajadores, y también puede tener derecho a ciertos beneficios médicos y moneturios. Para mayor información comuniquese con la oficina local de la División al teléfono 1-800-252-7031.

| 2. TEXAS WORKERS' COMPENSA | TION WORK STATUS REPORT | |
|---|---|---|
| PARTI, GENERAL INFORMATION | Sig. Shallo Mil | (for transmission purposes only) Date Being Sent |
| Injured Employee's Name LARA, JORGE | Clific/Facility Name Allied Medical Center | 9. Employer's Name CES ENVIROMENTAL |
| 2. Date of injury 3. Social Security Number 7. 7/12/2009 xxx-xx- | Cinic/Facility/Doctor Phone & Fax (713) 450-2838(713) 450-2843 | 10. Employer's Fax # or Email Address (if known) (713) 676-1676 |
| 4. Employee's Description of Injury/Accident 8. | Clinic/Facility/Doctor Address (street address) | 11. Insurance Carrier |
| Involved masses | | 12. Carrier's Fax # or Email Address (if known) |
| explosion. | Houston TX, 77029 | |
| PART II: WORK STATUS INFORMATION (FU | LLY COMPLETE ONE INCLUDING ESTIMATED DATE | S AND DESCRIPTION IN 13(c) AS APPLICABLE) |
| 13, The injured employee's medical condition res | | |
| (a) will allow the employee to return to work (b) will allow the employee to return to work | as of (date) <u>without restrictions</u> . | dentified in PART III which are |
| A expected to last through (date). | 1/ / | |
| (c) has prevented and still prevents the empl through (1) O date). The following descriptions | oyee from returning to work as of | date) and is expected to continue |
| through (170) date). The following desc | noes now this injury prevents the employee m | on returning to work. |
| PART III: ACTIVITY RESTRICTIONS* (ONLY | | |
| 14, POSTURE RESTRICTIONS (if any): | 17. MOTION RESTRICTIONS (if any): | 19. MISC. RESTRICTIONS (if any): |
| Max Hours per day: 0 2 4 6 8 Other | Max Hours per day: 0 2 4 6 8 Other | Max hours per day of work: |
| Standing | Walking | Sit/Stretch breaks of per |
| Sitting ODD | Climb stairs/ladders | ☐ Must wear splint/cast at work |
| Kneeling/Squatting | Grasp/Squeeze | Must use crutches at all times |
| Bending/Stooping | Wrist flex/extension | ☐ No driving/operating heavy equipment ☐ Can only drive automatic transmission |
| Pushing/Pulling UUUU | Reaching | ☐ Ne work / ☐ ——bours/day work: |
| Other: | Keyboarding | in extreme hot/cold environments |
| 15. RESTRICTIONS SPECIFIC TO (if applicable): | Other: | at heights or on scaffolding |
| ☐ L'Hand/Wrist ☐ R Hand/Wrist | 18. LIFT/CARRY RESTRICTIONS (if any): | ☐ Must keep: |
| □ LArm □ RArm □ Neck | ☐ May not lift/carry objects more thanlb: | |
| ☐ LLeg ☐ RLeg ☐ Back | for more than hours per day | ☐ No skin contact with: |
| L Foot/Ankle R Foot/Ankle | May not perform any lifting/carrying | ☐ Dressing changes necessary at work |
| Other: | Other: | ☐ No Running |
| 16. OTHER RESTRICTIONS (if any): | | 20. MEDICATION RESTRICTIONS (if any): |
| | | ☐ Must take prescription medication(s) |
| * These restrictions are based on the doctor's best under | standing of the employee's assential job functions. If | Advised to take over-the-counter meds |
| particular restriction does not apply, it should be disregard | led. If modified duty that meets these restrictions is n | ot medication may make drowsy |
| available, the patient should be considered to be off work. N as well as at work. | Die - triese restrictions should be fallowed dutate of wa | in (possible data), and any and any |
| PART IV: TREATMENT/FOLLOW-UP APPOL | NTMENT INFORMATION | |
| | nected Follow-up Services Include: _ | 26- |
| 1-1 Junton 8PLST & EV | aluation by the treating doctor on UC | (date) at :am/pm |
| | ferral to/Consult with | on (date) at ; am/pm |
| | ysical medicineX per week forweeks start ecial studies (list): | |
| | Soldi Gradiae (1104). V - O O TO | on (date) at :am/pm |
| Date / Time of Visit NEMPLOYEE'S SIGNATURE | | m. At this time, no further medical care is anticipated. t Type: Role of Doctor: Treating doctor |
| 9/20/09 | | nittal Designated doctor Referral doctor |
| Discharge Time / pesed | real less | Carrier-selected RME Consulting doctor |
| 4 | | ☐ TWCC-selected RME ☐ Other doctor |
| 1 1 | | |

DWC FORM-73 (Rev.10/05) Page 1



Howard, Bruce

7-7-09

EPAHO042001794



07/22/2009

C E S ENVIRONMENTAL SERVICES I 4904 GRIGGS RD HOUSTON TX 77021-3208

Notification Confirming Receipt of Claim

Date of Injury: Injured Worker: Claim Number: 07/07/2009 IIOWARD, BRUCE (b) (4)

0001086044

Policy Number:

Attached is a copy of the information you reported to Texas Mutual Insurance Company which was used to establish this claim. You may submit additional claim information to Texas Mutual Insurance Company. If you have questions regarding this report of injury please contact us at (800) 859-5995.

If your policy includes our workers' compensation health care network option you are required by law to obtain a second Employee Acknowledgement of Workers' Compensation Network Form signed by the injured worker. Please submit a copy of the signed, second acknowledgement form to Texas Mutual Insurance Company. You can find a copy of the form online at www.texasinutual.com/hcn/shtm

Below please find information that will help you through the claim process:

To submit additional claim information:

Mail to: P. O. Box 12029 Austin, Texas 78711-2029 Fax to: (512) 224-3889 To locate a treating doctor:

www.texasmutual.com/workers/iwADL.shtm

To contact the handling adjuster:

Call: (800) 859-5995

Monday - Friday; 8:00 a.m. - 5:30 p.m.

To obtain a copy of the Employer and Employee Rights and Responsibilities in the Workers' Compensation System:

www.texasmutual.com/employers/erRights.shtin

To locate a pharmacy, or for pharmacy questions, contact Scripnet:

Call: (888) 880-8562 www.scripnet.com

To obtain a copy of the Employer and Employee Rights and Responsibilities for the workers' comp health care network: www.texasmutual.com/hen/hen.shtm

Additional Texas Mutual® online services at www.texasmutual.com, available 6 a.m. - 9 p.m., include:

- o Obtain logon id, or for immediate logon id. call (800) 859-5995, M-F, 8:00 a.m. 5:30 p.m.
- o Submit first report of injury in the Employers section
- o Submit wage statement when reviewing loss runs and claim details
- o Obtain specific claim summary information



Claim Number:

99K000057565301

Notification Date: 07/08/2009

EMPLOYER'S FIRST REPORT OF INJURY

INJURED EMPLOYEE **BUSINESS/EMPLOYER** Name: BRUCE HOWARD Name: CES ENVIRONMENTAL SERVICES I SSN: XXX-XX(b)Address: Mailing 4904 GRIGGS RD HOUSTON TX 77021-3208 Address: TX Phone: (713)676-1460 Ext: Fax: (713)676-1676 County: **Policy Number:** 0001086044 Physical Address: FEIN: 760592985 Location ID: County: **EMPLOYMENT** Home Phone: Occupation: **Date of Birth:** 00/00/0000 Hire Date: 00/00/0000 State: TX Marital Status: Unknown Partner/Officer/Owner: Gender: Dependents: 00 Male Date Lost Time Began: 00/00/0000 Language: English Return to Work Date: 00/00/0000 Last Paycheck was: **MEDICAL PROVIDER** Wage: Frequency: Name: Tax ID: Hours/Week: Days/Week: **Period Start:** 00/00/0000 Period End: 00/00/0000 Address: Supervisor Name: Phone: Ext: Phone: Fax: PREPARER OF REPORT **ATTORNEY** Name: Represented by Attorney: Phone: Ext: Fax: Name: Email: Phone:

INJURY INFORMATION

TX

Address Where Injury Occurred:

Date Reported: 00/00/0000 Nature of Injury: BURN

Time: 00:00

County: Witnesses:

Cause of Injury: BURN/SCALD HEAT OR COLD Name: EXP-CONTACT/W NOC

Phone: Name:

UNKNOWN/ NOT Part of Body: Phone:

REPORTED Name:

Fatality: Yes Phone:

How and Why the Injury/Illness Occurred

FATALITY. BURNS. EXPLOSION.

Date of Injury: 07/07/2009



07/13/2009

Texas Department of Insurance Division of Workers' Compensation

7551 Metro Center Dr., Ste 100, MS-96, Austin, TX 78744-1609 Voice 512.804.4636 Fax 512.804.4101 www.tdi.state.tx.us

CES ENVIRONMENTAL SERVICES INC 4904 Griggs Rd Houston, TX 77021-3208

RE:

Claim No.:

(b) (4)

ed Worker: BRUCE HOWARD

Injured Worker: Date of Injury:

07/07/2009

Carrier Name: Carrier No.: Texas Mutual Insurance Co

99K0000575653

NOTICE TO EMPLOYER

The Texas Department of insurance, Division of Workers' Compensation (DWC) has received notice of an injury/death on the above-named employee. Enclosed is information about your rights and responsibilities as an employer and information to help you develop successful return to work procedures. Services available from DWC to assist employers include:

RETURN TO WORK SERVICES: DWC provides information to help employers reduce costs and control lost time by successfully returning injured workers to productive work as soon as possible following an injury. A "Resource Guide" and other information are available on DWC website. In addition, workshops, seminars, and individual consultations also are available.

<u>OSHCON</u> - Free health and safety consultations are provided to small private employers on request. Emphasis is placed on assisting the employer in developing effective health and safety programs and identifying and correcting hazards in the workplace, including industrial hygiene testing.

<u>Safety Information Library</u> - Health and safety training programs are available to employers, employees, academic institutions and other entities in Texas. Additionally, the Division maintains a resource center containing health and safety information, visual aids, and publications. A large number of safety educational materials are available for download from the Division's web site. The Division staff also provide assistance with research on specific health and safety issues and questions.

<u>Safety Education & Training</u> - Onsite professional occupational safety training is available to public and private employers throughout the State of Texas. We can help any Texas business, whether or not the company subscribes to workers' compensation.

More information on these services can be located on the Division's website at www.tdi.state.tx.us.

Your workers' compensation insurance carrier is required to notify you of any claim filed against your policy. You may submit a written request to your insurance carrier to secure additional information regarding payments, reserves, and the effect on premium rates set by the Texas Department of Insurance. This information is intended to inform you of the means to secure specific information regarding your company's workers' compensation claims. Please direct your questions regarding premium rates to the Texas Department of Insurance, Workers' Compensation Division, 333 Guadalupe Street, Austin, Texas 78701 (telephone 512-322-3495).

If you prefer this information be mailed to an address other than **4904 Griggs Rd**, **Houston**, **TX 77021-3208**, please contact your workers' compensation insurance carrier, who will advise the Division of any address changes. Future mailings will be forwarded to the corrected address.

THIS NOTICE DOES NOT REQUIRE A RESPONSE.

Sincerely,

Texas Department of Insurance, Division of Workers' Compensation

Enclosure:

Rights and Responsibilities

CS-37 (10/05)

An Equal Opportunity Employer



45451951000061020

Employer Rights and Responsibilities under the Texas Workers' Compensation Act

For further information about your rights and responsibilities, please refer to the Texas Workers' Compensation Act (Texas Labor Code, Title 5, Subtitle A) and to the administrative rules of the Texas Department of Insurance, Division, of Workers' Compensation. For specific information, please write the Division at 7551 Metro Center Drive, Suite 100, Austin, TX 78744-1609, or call 1.800.252.7031 to be connected to the field office nearest you or

EMPLOYER RIGHTS

The Texas Workers' Compensation Act, Texas Labor Code, Section 409.011, provides covered employers the following rights:

- to be present at all administrative proceedings related to a claim
- To present relevant evidence related to a claim at any proceeding
- to report suspected fraud
- to contest the compensability of an injury if the insurance carrier accepts liability for the payment of benefits.
- to receive notice, after making a written request to the insurance carrier, of
 - an administrative or a judicial proceeding related to the resolution of a claim; or
 - · a proposal to settle a claim
- to contest the failure of the insurance carrier to provide accident prevention services required by the Act.

EMPLOYER RESPONSIBILITIES

1) Reporting Injuries

Employer's First Report of Injury: You must report to your insurance carrier within 8 days of the date you receive notice or have knowledge of:

- a work-related injury that causes an employee to miss more than 1 day of work
- an occupational illness that you know about, even if the employee has not missed any work
- · a work-related death

Do not file an employer's First Report of Injury with the Texas Department of Insurance, Division of Workers' Compensation unless specifically requested to do so.

You may report injuries by mail, fax, telephone, or electronic transmission to your insurance carrier. Failure to timely report an injury or illness may result in an administrative penalty not to exceed \$500 to be assessed by the Division. Send a copy to the injured worker and provide the employee a summary of rights and responsibilities in the wording adopted by the Division.

You must keep a record of work-related injuries, illnesses, and deaths. Keep the records for at least 5 years from the last day of the year in which the injury, illness, or death occurred, or for the period of time required by the Occupational Safety and Health Administration, whichever is greater.

2) Other Reporting Responsibilities

Employer's Wage Statement:

You must report an injured worker's wages and other compensation to your insurance carrier. Send Form-3, Employer's Wage Statement, to your insurance carrier within 30 days of the date income benefits begin to accrue. Send a copy of the form to the injured worker. Do not file the form with the Division unless specifically requested to do so.

Supplemental Report of Injury: You must report any changes in an injured worker's pay or employment status to your insurance carrier. Send Form-6, Supplemental Report of Injury, to your insurance carrier within:

- 3 days of the date the injured worker returns to work;
- 3 days of the date an injury causes the employee to miss additional work after returning to work;
- 10 days of the end of a pay period in which the injured worker's weekly earnings change as a result of the injury;
- 10 days of the date the injured employee resigns or is terminated.

Send a copy of the form to the injured worker. Do not file the form with the Division unless specifically requested to do so.

If you do not timely send the required forms to the insurance carrier and the injured worker, you could be subject to a penalty of up to \$500 per occurrence for the Employer's Wage Statement and the Supplemental Report of Injury.

3) Posting and Notice Responsibilities

(This section does not apply to Political Subdivisions)

Notice of Coverage or Change in Coverage: You must post notices in your workplace telling your employees that:

- You have workers' compensation insurance and provide the name of your workers' compensation insurance carrier:
- the Division has staff to explain injured workers' rights and responsibilities and to help resolve disputes about their claims;
- the Division has a 24-hour, toll free hotline to report suspected safety violations in the workplace.

Posted notices must be in wording and format adopted by the Division. If you do not post these notice, you could be subject to a penalty up to \$500.

You must give all of your employees written notice if you cancel; your workers' compensation policy within 15 days of the date you cancel your policy or are notified that your insurance carrier intends to cancel you policy. If you do not provide this notice to your employees, you could be subject to a penalty up to \$500 per occurrence.

Employer Rights and Responsibilities under the Texas Workers' Compensation Act

For further reformation about your rights and responsibilities, phases nater to the Teres Morter's Companisation Act (Feres Labor Costs 70% 2 Subbits A) and to the administrative rules of the Teres Department of Insorprise Division of Michael Companisation. For appetite, information opening with the Division of 75th Matter Costs. Division of Feres 1600 or call (40%) to be consected to the field of contract you or

Notice to new Employees: You must give each new employee at the time of hire a written notice that includes the information in the posted notices. The written notice must also tell new employees that they have the right to choose not to be covered by your workers' compensation policy. Employees have 5 days from the date they begin employment to notify you in writing if they do not want to be covered by your policy. The written notice to new employee must be in wording adopted by the Division. If you do not provide this notice to new employees, you could be subject to a penalty up to \$500 per occurrence.

For Copies of the required notices, call 512-804-4333, or write DWC Forms, MS-91, 7551 Metro Center Drive, Suite 100, Austin, TX 78744-1609.

4) Other Responsibilities

Drug Policy, if required: If you have 15 or more employees, you must have a policy to eliminate drug abuse in your workplace. You must give a copy of the policy to each employee.

For a free copy of the Division's Drug-Free Workplace Resource Guide, which includes information on development of a drug-free workplace policy, call 512-804-4624 or write DWC Health and Safety Resource Center, MS-25, 7551 Metro Center Drive, Suite 100, Austin, TX 78744-1609. The Drug-Free Workplace Resource Center Publications/Videos at our website (www.tdi.state.tx.us).

Accident Prevention Plan, If required: If you are identified by the Division as a hazardous employer or are identified by the Texas Mutual Insurance Company to participate in an injury prevention program, you must adopt an accident prevention plan developed by an approved consultant who may be from the Division or your insurance carrier, or may be a Division-approved provider. The initial consultation must occur within 30 days of the date you receive notice that you have been identified to participate in an accident prevention program.

ADMINISTRATIVE AND CRIMINAL VIOLATIONS

Fraud: You could be subject to a penalty up to \$5,000 and possibly referred for criminal fraud investigation if you knowingly or intentionally commit an act to deny workers' compensation benefits to someone legally entitled to receive benefits. You also could be liable for past payments and interest.

Charge Backs: You may not charge your workers' compensation premiums back to your employees either directly or indirectly. If you charge premiums back to employees, you could be subject to a penalty up to \$1,000 per violation. Your employees may also recover damages in court.

Misrepresentation of Payroll: You could be subject to a penalty up to \$5,000 per occurrence if you intentionally misrepresent your payroll or provide false information to obtain lower insurance premiums. You could also be held liable for missed premiums.

Discrimination Against Employees: Texas law prohibits discharging or discriminating against an employee because the employee in good faith filed a workers' compensation claim, hired an attorney, testified, or will testify in a workers' compensation proceeding.



Return to Work Program for Employers

The Taum Depondent of of formations. Division of Workers's Congression with Albert is provided.

Rains to higher information or you was to silvent to high and disculy resonant work for your confidences.

By providing meaningful, productive work for your injured workers during his or her recovery, you can reduce your workers' compensations costs significantly.

Because your experienced and trained employees are continuing to do productive work for your company, you will be paying earned wages instead of workers' compensation income benefits. Most often, being away from work is medically unnecessary and can result in additional complications to the injury, delaying recovery and increasing the negative impact of the injury on injured workers and their families.

Talk to your insurance adjuster as soon as an injured worker begins to lose time from work.

Your insurance carrier can provide return to work coordination services to help you reduce unnecessary lost time and help your employees to continue to work during their recovery. Your adjuster also can help you understand the functional capabilities of your employees and help you work with health care providers as your employees recover.

It is important to help an injured worker focus on recovery.

Returning to a normal routine, including employment, as soon as possible is an integral part of the recovery process. Studies have shown that being off work longer than absolutely necessary can cause additional physical complications that could not only delay recovery but also increase your workers' compensation costs. Additional studies have shown that injured workers who continue to work require less medical care; therefore, you not only be paying lower medical costs for these employees but also over time should have lower workers' compensation premiums.

If an injured worker is unable to perform his or her regular duties, consider allowing the employees to perform a different job, within their capabilities, that is still important to the daily operations of your organization.

Modified or alternate assignments that are transitional in nature make it possible for the injured workers to stay engaged as productive members of the workplace. Consider modifying injured workers' work hours or allowing the injured workers to work at a slower pace. By remaining active in your employee's recovery process you not only help your business but you also increase the likelihood that your employees will continue to be productive members of the workforce.

DWC provides information to help employers with successful stay at work/return to work efforts. The information is available on the DWC website at http://www.tdi.state.tx.us/ or the information can be mailed to you. To request a copy of the Employers Resource Guide, or for specific assistance or questions, please call DWC at (512) 804-4804, or e-mail rtw@.tdi.state.tx.us.

You also can contact your local DWC Field Office. It is essential that all system participants work together to help injured workers stay motivated in the recovery and return to work process.

Thank you in advance for your interest and cooperation in this process.

CES Environmental Services, Inc.

INCIDENT REPORT Accident Near Miss DATE OF INCIDENT: 9-9-09 TIME: 4.00 a.m. RESULT OF INCIDENT: For Accidents check all that apply, for Near Misses ONLY 6 & 7 may be checked. 2) EXPLOSION 3) EQUIPMENT DAMAGE 4) PROPERTY DAMAGE 5) PRODUCT LOSS 6) PRODUCTION LOSS 7) EMPLOYEE ENDANGERMENT 8) OTHER PERSON(S) DIRECTLY INVOLVED Name: Name: EXACT LOCATION WHERE INCIDENT OCCURRED: 4904 Gras Rd. Houston TX Tank Wash Boy 5 DESCRIBE FULLY HOW INCIDENT OCCURRED: Bruce vas performing a tank wash was fanding on the cut walk / top of Tanker. Some how to be full from the top of the tracker to the grown RECOMMENDATIONS TO PREVENT REOCCURRENCE: COMMENTS: It is unknown at this time how or what religed from the WITNESSES (Print): Name: Jorge Prepared by (Print): 1050 Approved by (Print):___ Safety Representative Notified (Name): JOSE 140571

Rev 8.01



Special Services P.O. Box 12029 Austin, TX 78711-2029 Phone: (800) 859-5995 Fax: (512) 224-3889

| TQ: | FROM: | |
|--|----------------------------------|------------------|
| Juanita Thomas | Diane Thiele X 7903 | |
| COMPANY: C E S Environmental Service | DATE: 07/09/09 | |
| recipients fax number: 713-748-8664 | RECIPIENTS PHONE NUMBER: | |
| Bruce Howard Carrier Claim # (b) (4) | TOTAL NO. OF PAGES (INCLUDI) 2 | NG COVER): |
| ☐ URGENT ☐ FOR REVIEW | □ please comment ☑ please reply | □ please recycle |

CONFIDENTIALITY NOTICE

This fax is confidential and is for the sole use of the intended recipient(s) identified above. This message may contain information that is privileged, confidential, or otherwise protected from disclosure under applicable law. If the receiver of this information is not the intended recipient, or the employee, or agent responsible for delivering the information to the intended recipient, you are herby notified that any use, reading, dissemination, distribution, copying or storage of this information is strictly prohibited. If you have received this information in error, please notify the sender by return fax or dispose of the fax.

Send to workers' compensation carrier:

Texas Mutual 713-316-2191

(Name and fax number of carrier)



| CLAIM# |
|------------------|
| CARRIER'S CLAIM# |

☑ Initial □ Amended

EMPLOYER'S WAGE STATEMENT

The Texas Workers' Compensation Act and Workers' Compensation rules require an employer to provide an Employer's Wage Statement to its workers' compensation insurance carrier (carrier) and the claimant or the claimant's representative, if any. The purpose of the form is to provide the employee's wage information to the carrier for calculating the employee's Average Weekly Wage (AWW) to establish benefits due to the employee or a beneficiary.

The AWW is based on the wages the employee earned in the 13 weeks immediately preceding the date of injury (or the wage a similar employee earned if the employee did not work the full 13-week period). "Wages" include all forms of remuneration payable to an employee for personal services, including fringe benefits. To simplify filing, employers may file wages in a monthly, biweekly, or weekly manner as discussed below.

NOTE - An employer who fails without good cause to timely file a complete wage statement as required by the Texas Workers' Compensation Act, Texas Labor Code, Section 408.063(c) and Worker's Compensation Rule 120.4 may be assessed an administrative penalty not to exceed \$500.00 for an initial offense and not to exceed \$10,000.00 for a repeated administrative violation.

The employer shall timely file a complete wage statement in the form and manner prescribed by the Division.

- (1) The wage statement shall be filed ("filed" means received) with the carrier, the claimant, and the claimant's representative (if any) within 30 days of the earliest of:
 - (A) the employee's eighth day of disability;
 - (B) the date the employer is notified that the employee is entitled to income benefits;
 - (C) the date of the employee's death as a result of a compensable injury.
- (2) The wage statement shall also be filed with the Division within seven days of receiving a request from the Division (Only When Requested).
- (3) A subsequent wage statement shall be filed with the carrier, employee, and the employee's representative (if any) within seven days if any information contained on the previous wage statement changes (such as if the employer discontinues providing a nonpecuniary wage that was initially continued after the date of injury).

All applicable DWC rules can be found at www.tdi.state.tx.us

| | <u></u> | | | | | | |
|--|--|--|--|--|--|--|--|
| EMPLOYEE AND EMPLOYER INFORMATION | | | | | | | |
| Employee's Name (Last, First, M.I.): | Employer's Business Name: | | | | | | |
| Howard, Bruce | CES Environmental Services, In | | | | | | |
| Employee's Mailing Address (Street or P.O. Box): | Employer's Mailing Address (Street or P.O. Box): | | | | | | |
| (b) (4) | 4904 Griggs Rd | | | | | | |
| City: State: ZIP Code: | City: State: ZIP Code: | | | | | | |
| (b) | Houston TX 77021 | | | | | | |
| Social Security Number (last four digits): | Federal Tax I.D. Number: | | | | | | |
| (b) (4) | 76-0592985 | | | | | | |
| Date of Hire: Date of Injury: | Name and Phone # of Person Providing Wage Information: | | | | | | |
| 7/07/09 | Jose Acosta | | | | | | |
| ☑ As of today's date, the employee is not back at work. ☑ The employee returned to work on and is working: | I HEREBY CERTIFY THAT this wage statement is complete, accurate, and | | | | | | |
| □ without restriction. OR □ with restrictions and is earning wages of \$ per week/month (circle one). | complies with the Texas Workers' Compensation Act and applicable rules, and the listed wages include all pecuniary and nonpecuniary wages paid for (earned in) the 13 weeks prior to the date of injury (as described on page 2) and I understand that making a misrepresentation about a workers' | | | | | | |
| NOTE – Rule 120.3 requires the employer file the Supplemental Report of Injury (DWC FORM-6) to report changes in Work Status and Post-Injury Earnings. | compensation claim is a crime that can result in fines and/or imprisonment. Signature:Date: | | | | | | |
| EMPLOYMENT STATUS AT TIME OF INJURY (Check A | II That Apply) | | | | | | |

- ☑ Full-time: employee who regularly works at least 30 hours per week and whose schedule is comparable to other employees of the company and/or other employees in the same business or vicinity who are considered full-time.
- ☐ Seasonal: employee who as regular course of conduct engages in seasonal or cyclical employment that may or may not be agricultural in nature and that does not continue throughout the year.
- ☐ Part-time: Regular Course of Conduct: employee whose work history for the 12-month period preceding the injury shows the person only worked part-time during that period.
- ☐ Part-time: Not Regular Course of Conduct: employee whose work history for the 12-month period preceding the injury shows part-time and full time work during that period.
- ☐ Apprentice: employee who is learning a skilled trade or art by practical experience under the direction of a skilled crafts person or artisan.
- ☐ Minor: employee less than 18 years of age and not emancipated by marriage or judicial action who is also an apprentice, trainee or student.
- ☐ Student: employee enrolled in a course of study in high school, college or other institute of higher education or technical training.
- ☐ Trainee: employee undergoing systematic instruction and practice in some art, trade or profession with a view towards proficiency in it.

SAME OR SIMILAR EMPLOYEE?

The wage information on this form is for:

☑ The Injured Employee OR ☐ A Similar Employee (NOTE – If requested by the Division, the employer shall identify the similar employee whose wages were provided.)

If the employee was not employed for 13 continuous weeks before the date of injury, report the wages of an employee who has training, experience, skills & wages comparable to the injured employee AND who performs services/tasks comparable in nature and in number of hours. If no similar employee exists, report the limited available wages earned by the injured employee prior to the injury.

NOTE TO INJURED EMPLOYEE – If you were injured on or after 7/1/02, and had employment with more than one employer on the date of injury, you can provide your insurance carrier with wage information from your other employment for the carrier to include in your AWW and this may affect your benefits. Contact your carrier for additional information or call the Division at (800) 252-7031. You can also read rule 122.5 at www.tdi.state.tx.us.

| | | ION INSTRU | ICTIONS |
|------------|---------|------------|---------|
| YV / LUI - | INFURNA | IONINSIRU | JULIUNG |

Howard, Bruce

Social Security # 4030

Nonnecuniary Wages include all wages paid to the employee in a form other than money. These include, but are not limited to the

Date of Injury: 7/07/09

- The employer shall report all wages earned in the 13 weeks immediately preceding the date of injury. If the employee is paid on a monthly or semi-monthly basis, the employer may provide wages for the 3 months preceding the date of injury. Monthly wages may also be converted to weekly wages by dividing the gross monthly amount by 4.34821. If the employee is paid on a biweekly basis, the employer may provide the wages for the 14 weeks preceding the date of injury. When setting the periods to report, the employer may adjust the reporting period backward slightly (up to six days) to line up the reporting timeframes with the employer's natural pay cycle. However, the employer shall not report wages earned on or after the date of injury.
- If reporting weekly earnings, use all 13 Period Columns below. If reporting 3 months of earnings, either convert the wages to weekly earnings or use the first 3 Period Columns. In all cases, indicate the dates that each period covers.

| PECUNIARY WAGE II | hourly, we commission commission use of the | ekly, biweel ons. Eaming ons) need to employee's | kly, monthly gs are repo be prorated equipment | , etc. wages rted in the . Pecuniary or for paying | s; salary; tip periods they wages don g helpers or | s/gratuities; y are earned t include pay | piecework o d, NOT who yments mad e for travel o | compensation they are by an empenses. (| on; monetar paid and s ployer to rei Consider as | y allowances ome (such a mburse the e earnings am | re not limited to: s; bonuses; and ss bonuses and employee for the nounts from paid not used. | | | |
|---|---|---|---|---|---|--|---|---|---|--|---|---------|----------|--------|
| PERIOD # (Week #, Month #, or Bi-Week #) | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | |
| FROM DATE: | 1/11/09 | 1/18/09 | 4/20/09 | 4/26/09 | 5/03/09 | 5/10/09 | 5/17/09 | 5/24/09 | 5/31/09 | 6/07/09 | 6/14/09 | 6/21/09 | 6/28/09 | |
| TO DATE: | 1/17/09 | 1/24/09 | 4/25/09 | 5/02/09 | 5/09/09 | 5/156*/08 | 5/23/09 | 5/30/09 | 6/06/09 | 6/13/09 | 6/20/09 | 6/27/09 | 07/04/09 | TOTALS |
| # HOURS WORKED: | 46.05 | 20.22 | 48.07 | 48.24 | 47.29 | 46.10 | 45.35 | 52.09 | 43.17 | 53.05 | 47.23 | 53.02 | 52.09 | 601.97 |
| GROSS WAGES EARNED: | (b) (4) | | | | | | | | | | | | | |

| NONPECUN | JIARY | WAGE | INFOR | EMATIC | אר | | | | | | | | | | | | | ioi iimitea ta, the |
|---------------------------|---------|----------------------------|-------|---------------|----------|---------|--|---|---|---|---|----|----|----|----|------------|----------------------------|---------------------------------------|
| | | | | | | | | | | | | | | | | e to purch | | |
| Nonpecuniary Wage Type | Provide | loyer ed Prior jury? | Spe | cify Valu | ue Or An | ount Ea | ount Earned in Each Reported Period For Each Benefit Provided Prior To Injury (Use the same periods as used above) | | | | | | | | | | nployer nue To ride? | Date Benefit Suspended (if suspended) |
| | YES | NO | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | YES | NO | 1 |
| Health Insurance | | | | | | | , | | | | | | | | | | | |
| Laundry/ Cleaning | : | | | | | | | | | | | | | | | | | |
| Clothing/ Uniforms | | | | | | | | | | | | | | | | | | |
| Lodging/ Housing/ | | | | | | | | | | | | | | | | | | |
| Food/ Meals | | | | | | | | | | | | | | | | | | |
| Vehicle/ Fuel | | | | | | | | | | | | | | | | | | |
| Other | | | | | | | | | | | | | | | | | | |





Claim & Information Services
P.O. Box 12029
Austin, TX 78711-2029
1-800-859-5995 (512) 224-3800
Fax (512) 224-3889

July 9, 2009

C E S ENVIRONMENTAL SERVICES 4904 GRIGGS RD HOUSTON, TX 77021-3208

Re:

Claim#;

Employee: Soc. Sec.:

Employer: Date of Injury: BRUCE HOWARD
(b) (4)

C E S ENVIRONMENTAL SERVI

of Injury: 07/07/2009

DWC#:

In accordance with the Division of Workers' Compensation Rules, we are requesting that you submit the information indicated below. The DWC3 and DWC6 forms are available for printing from our website, www.texasmutual.com, under services, or from the division's website, www.texasmutual.com, under services, or from the division's website, www.texasmutual.com under the Employers - Loss Run & Claims Detail Section. If you need assistance with filing the DWC3 on-line please contact me. If you do not have access to the Internet, we will be happy to send you a blank form.

DWC3 EMPLOYER'S WAGE STATEMENT (Rule 128.2) - Please fax or email attachment or use the on-line version (www.texasmutual.com).

OR

DWC3SD EMPLOYER'S WAGE STATEMENT FOR SCHOOL DISTRICTS (Rule 128.7)

DWC6 EMPLOYER'S SUPPLEMENTAL REPORT OF INJURY OR ILLNESS (Rule 120.3) - Please fax or email attachment. The following time frames apply.

Within 10 days after:

- The end of each pay period in which the employee's carnings have changed as a result of the injury, OR.
- The employee resigns or is terminated.

Within 3 days after:

- The employee begins to lose time from work as a result of the injury, OR
- The employee returns to work, OR.
- The employee, after returning to work experiences an additional days(s) of disability as a result of the injury.

Pailure to provide the required information is an administrative violation and may result in the assessment of a penalty from the Division of Workers' Compensation.

AND

EMPLOYEE ACKNOWLEDGEMENT OF WORKERS' COMPENSATION NETWORK FORM (This form(s) shall be completed, signed and submitted). Please fax or send attachment via email as soon as possible.

☐ COPY OF THE POST-ACCIDENT DRUG SCREEN RESULTS

Thank you for your prompt attention to this matter. If you have any questions, please call me at 1-800-859-5995 ext. 7903.

Sincerely,

Diane Thicle

CAT WORKERS' COMP SPEC II

Dune Lhelo.

******** -IND. XMT Journal- ********* Date JUL-10-2009 **** Time 09:47 *******

Date/Time = JUL-10-2009 08:28

Journal No. = 121

Comm. Result = OK

Page(s) = 001/001

Duration = 00:00:29

File No. = 758

Mode

= Memory Transmission

Destination = 15612417305

Received ID =

Resolution = Fine

-CES ENVIROMENTAL

***** DP-C264 ****************************

_ **** _

7137488664- ******

| * | | | | | • | | | |
|---|--|-------------------------|----------|-----------------------|------------------------|---------------------------------|---------------------------|---------------------------------------|
| Send the specified copies to Workers' Compensation in and the injured employee. *Employers - Do not send to | surance Carrier | 7 | TWCC (| CLAIM# | | | | |
| Texas Workers' Compensa unless the Commission speadirect filing. | | | CARRIE | R'S CLAIM# | ! | | | |
| | EMPLOYER'S | CIDST DED | OPT O | E IN ILIBÝ (| OD ILL NE | cc | | |
| 1. Name (Last, First, M.I.) | 2. Sex | TIKS I KEP | ט ואנ | 15. Date of | | 16. Time of Injury | Id7 Data last | Time |
| Assorb Brush Br | uce C | ☆ M | | 7-7-6 | 99 | Ц∖•О □ am X pr | 7-7-0 | ٩ |
| 3. Social Security No. | proc Phone 5. Date of Birth | | 1 | 18. Nature o | f Injury* | 19. Part of Body Ir | njured or Expos | sed* |
| (b) (4) | 3-22-6 | ` | | Death | | | | |
| Does the Employee Speak En | glish? If No. Specify Langua | ge | | | | //illness Occurred* | | |
| ¥∑Yes | No | | | | | n tank tr | | |
| 7. Race 8. Et | hnicity | | 1 | | _ | ry or Exposure Oc | | |
| Plack | | | | | | incident occurred | | |
| | | | | 4904 (| | | ENVINNA | <u>~}<\/</u> |
| (b) (4) | | | | City <i>Harsto</i> | | Tx | Zip 7702) | • |
| (b) (4) | Zin Coun ty | ′ [| | 24. Cause of | Injury(fail, | tool, machine, etc. |)* | İ |
| 10. Mantal Status: Single | <u></u> | | | Encry | il from | ~ tank tv | vcK | |
| 11. Number of Dependent Childre | n 12. Spouse's Na | ame | | 25. List With | 1 | ira | | |
| 13. Doctor's Name; | | | ſ | 26. Return to | Work | 27. Did employee | 28. Super- | 28. Date |
| 14. Doctor's Mailing Address (Stre | et or P.O.Box) | | - | Date/or e | xpected | die? | visor's name | Reported |
| | | 1 | - 1 | وارر | | 1. | James | 7-7-09 |
| City State | Zip | | | N/I | } | Yes | James Phorma | 17. 1-0-1 |
| 30. Date of Hire 31. W | as employee hired or recruited | d in 32 | 2. Leng | th of Service | in | 33. Length of Ser | vice in Occupa | tion |
| (b) (4) | exas? 🔀 Yes 🗆 | No | - | ent Position | | (mm/us) | | |
| | ` | | 1 | muths | | 2 min | ths | |
| 14. Employee Payroll Classificatio | n Code | 35 | 5. Occu | pation of Inju | red Worke | T | | |
| 6. Rate of Pay at this job 37. F | ull Work Week is: 38. Las | t Paycheck wa | as: | 39. Is employ | ee an Owr | ner, Partner, or Co | rporate Officer | ?. |
| (b) (4) Meakly 50 | ours Days Hou | ırs Da | ays | | | | NI | |
| (b) (4) SO | 5 | | | | | Yes | No | · · · · · · · · · · · · · · · · · · · |
| 0. Name and Title of Person Com | pleting Form | 41 | | of Business | | () 2 | 7 | |
| Jose Austa A | >E Manager | | <u> </u> | 55 En. | <u>weign</u> | artal Servi | USILANG | |
| 2. Business Mailing Address and | | | 3. Busir | iess Location | ı (it dinerer | nt from mailing add | iress) | |
| 4404 Grigo's Rd- | Tel No: 713-6' | 7 6 - 1400 Ci | ih., | | Ctoto | | Zip | |
| Housdon T | 77021 | Ci | ıty | | State | | Zip | |
| 4. Federal Tax Identification Num 76059 2985 | ber 45. Primary Stan (SIC) Code* (| | l Class | ification | 46. Speci (4 digit) | fic SIC Code* | 47. Texas Co payer No. | mptroller Tax |
| 8. Workers' Compensation Insura | | 49 | Polic | / Number | 26 | 1 | | |
| Texas Mun | |) - ^ | | 20100C | <u> </u> | ~1 | | |
| Did you request accident preve | intion services in past 12 mont is, did you receive them? | | ۸۱۵ | | | | | |
| Yes the No Alf ye | | Yes Y | | SIGNING | | | | |

You may be seritled to know what information UT Arlington (UTA) collects concerning you. You may review and have UTA correct this information according to procedures set forth in UT System BPM #32. The law is found in sections 552.021, 552.-23 and 559.004 of the Texas Government Code.

Continued on next page

****** -IND. XMT Journal- ******** Date JUL-08-2009 **** Time 14:58 ******

Date/Time = JUL-08-2009 14:57

Journal No. = 105

Comm. Result = OK

Page(s) = 001/001

Duration = 00:00:27

File No. = 742

Mode

= Memory Transmission

Destination = 15122243889

Received ID =

Resolution = Fine

-CES ENVIROMENTAL -

***** DP-C264 *********************

_ **** _

7137488664- ******



Claim Number: 99K0000575653

Notification Date: 07/08/2009

EMPLOYED'S EIRST DEPORT OF INTURY

| EMILOTERSITI | AST REPORT OF INSURT |
|---|---|
| INJURED EMPLOYEE | BUSINESS/EMPLOYER |
| Name: SSN: Mailing Address: TX | Name: CESENVIRONMENTAL SERVICES I Address: 4904 GRIGGS RD HOUSTON TX 77021-3208 |
| County: Physical Address: County: | Phone: (713)676-1460 Ext: Fax: (713)676-1676 Policy Number: 0001086044 FEIN: 760592985 Location ID: EMPLOYMENT |
| Home Phone: Date of Birth: 00/00/0000 Marital Status: Unknown Gender: Male Dependents: 00 Language: English MEDICAL PROVIDER | Occupation: Hire Date: 00/00/0000 State: TX Partner/Officer/Owner: Date Lost Time Began: 00/00/0000 Return to Work Date: 00/00/0000 Last Paycheck was: Wage: Frequency: |
| Name: Tax ID: Address: | Hours/Week: Days/Week: Period Start: 00/00/0000 Period End: 00/00/0000 Supervisor Name: Phone: Ext: |
| Phone: Fax: | PREPARER OF REPORT |
| ATTORNEY | FREFAREN OF REPORT |
| Represented by Attorney: Name: Phone: | Name: Phone: Ext: Fax: Email: |
| INJURY IN | FORMATION |
| Date of Injury: 07/07/2009 Time: 00:00 Date Reported: 00/00/0000 Nature of Injury: BURN | Address Where Injury Occurred: TX |
| Cause of Injury: BURN/SCALD HEAT OR COLD EXP-CONTACT/W NOC | County: Witnesses: Name: Phone: |
| Part of Body: UNKNOWN/ NOT REPORTED | Name: Phone: |
| Fatality: Yes | Name: Phone: |

How and Why the Injury/Illness Occurred FATALITY. BURNS. EXPLOSION.



07/08/2009

C E S ENVIRONMENTAL SERVICES I 4904 GRIGGS RD IHOUSTON TX 77021-3208

Notification Confirming Receipt of Claim

Date of Injury: Injured Worker: Claim Number: Policy Number: 07/07/2009 HOWARD, BRUCE (b) (4)

0001086044

Attached is a copy of the information you reported to Texas Mutual Insurance Company which was used to establish this claim. You may submit additional claim information to Texas Mutual Insurance Company. If you have questions regarding this report of injury please contact us at (800) 859-5995.

If your policy includes our workers' compensation health care network option you are required by law to obtain a second Employee Acknowledgement of Workers' Compensation Network Form signed by the injured worker. Please submit a copy of the signed, second acknowledgement form to Texas Mutual Insurance Company. You can find a copy of the form online at www.texasmutual.com/hcn/shtm

Below please find information that will help you through the claim process:

To submit additional claim information:

Mail to: P. O. Box 12029 Austin, Texas 78711-2029 Fax to: (512) 224-3889 To locate a treating doctor:

www.texasmutual.com/workers/iwADL.shtm

To contact the handling adjuster:

Call: (800) 859-5995

Monday - Friday; 8:00 a.m. - 5:30 p.m.

To obtain a copy of the Employer and Employee Rights and Responsibilities in the Workers' Compensation System:

www.texasmutual.com/employers/erRights.shtm

To locate a pharmacy, or for pharmacy questions, contact Scripnet:

Call: (888) 880-8562 www.scripnet.com To obtain a copy of the Employer and Employee Rights and Responsibilities for the workers' comp health care network: www.texasmutual.com/hcn/hcn.shtm

Additional Texas Mutual® online services at www.texasmutual.com, available 6 a.m. - 9 p.m., include:

- o Obtain logon id, or for immediate logon id, call (800) 859-5995, M-F, 8:00 a.m. 5:30 p.m.
- o Submit first report of injury in the Employers section
- o Submit wage statement when reviewing loss runs and claim details
- o Obtain specific claim summary information

Sergio Torres 7.7-09

EPAHO042001811

Claim # Seralo Torres Send to workers' compensation carrier:

Texas Mutual 713-316-2191

(Name and fax number of carrier)



| CLAIM#_ | (b) (4) | |
|----------|----------|--|
| CARRIER' | S CLAIM# | |

| □ Initial | □ Amended |
|-----------|-----------|
|-----------|-----------|

Employee's Name (Last, First, M.I.):

EMPLOYER'S WAGE STATEMENT

The Texas Workers' Compensation Act and Workers' Compensation rules require an employer to provide an Employer's Wage Statement to its workers' compensation insurance carrier (carrier) and the claimant or the claimant's representative, if any. The purpose of the form is to provide the employee's wage information to the carrier for calculating the employee's Average Weekly Wage (AWW) to establish benefits due to the employee or a beneficiary.

The AWW is based on the wages the employee earned in the 13 weeks immediately preceding the date of injury (or the wage a similar employee earned if the employee did not work the full 13-week period). "Wages" include all forms of remuneration payable to an employee for personal services, including fringe benefits. To simplify filing, employers may file wages in a monthly, biweekly, or weekly manner as discussed below.

NOTE - An employer who fails without good cause to timely file a complete wage statement as required by the Texas Workers' Compensation Act, Texas Labor Code, Section 408.063(c) and Worker's Compensation Rule 120.4 may be assessed an administrative penalty not to exceed \$500.00 for an initial offense and not to exceed \$10,000.00 for a repeated administrative violation.

EMPLOYEE AND EMPLOYER INFORMATION

The employer shall timely file a complete wage statement in the form and manner prescribed by the Division.

- (1) The wage statement shall be filed ("filed" means received) with the carrier, the claimant, and the claimant's representative (if any) within 30 days of the earliest of:
 - (A) the employee's eighth day of disability;

Employer's Business Name:

- (B) the date the employer is notified that the employee is entitled to income benefits:
- (C) the date of the employee's death as a result of a compensable injury.
- (2) The wage statement shall also be filed with the Division within seven days of receiving a request from the Division (Only When Requested)
- (3) A subsequent wage statement shall be filed with the carrier, employee, and the employee's representative (if any) within seven days if any information contained on the previous wage statement changes (such as if the employer discontinues providing a nonpecuniary wage that was initially continued after the date of injury).

All applicable DWC rules can be found at www.tdi.state.tx.us

| Torres, Sergio | | CES Environm | ental Servic | es, In |
|--|--|--|--|--|
| Employee's Mailing Address (Street or P.O. Box): | | Employer's Mailing Addres | , | (): |
| (b) (4) | | 4904 Griggs Ro | | |
| City: State: Z | IP Code: | City: | State: | ZIP Code: |
| (D) (4) | | Houston | TX | 77021 |
| Social Security Number (last four digits): | | Federal Tax I.D. Number: | | |
| xxx-xx <mark>(b) (4)</mark> | | 76-0592985 | | |
| Date of Hire: Date of Injury | <i>/</i> : | Name and Phone # of Per | son Providing Wage I | nformation: |
| 8/01/07 7/07/09 | | Jose Acosta | | |
| ☐ As of today's date, the employee is not back ☐ The employee returned to work on ☐ without restriction. OR ☐ with restrictions and is earning wages of \$\frac{3}{2}\$ week/month (circle one). NOTE — Rule 120.3 requires the employer file the Injury (DWC FORM-6) to report changes in Work Earnings. | and is working: per Supplemental Report of | complies with the Texas and the listed wages inclu (earned in) the 13 weeks and I understand that | Workers' Compensat de all pecuniary and orior to the date of inj making a misrepres | nt is complete, accurate, and ion Act and applicable rules, nonpecuniary wages paid for jury (as described on page 2) sentation about a workers' fines and/or imprisonment. Date: |
| EMPLOYMENT STATUS AT TIME OF | INJURY (Check A | III That Apply) | , | |
| ☐ Full-time: employee who regularly works at least 30 hours per week and whose schedule is comparable to other employees of the company and/or other employees in the same business or vicinity who are considered full-time. ☐ Seasonal: employee who as regular course of conduct engages in seasonal or cyclical | employee whose work period preceding the inju worked part-time during the part-time: Not Regularity works work | ular Course of Conduct: history for the 12-month ry shows part-time and full | and not emancipa action who is also student. Student: employed | ee less than 18 years of age ted by marriage or judicial or an apprentice, trainee or oyee enrolled in a course of l, college or other institute of technical training. |

SAME OR SIMILAR EMPLOYEE?

employment that may or may not be agricultural in

nature and that does not continue throughout the

The wage information on this form is for:

The Injured Employee OR A Similar Employee (NOTE - If requested by the Division, the employer shall identify the similar employee whose wages were provided.)

If the employee was not employed for 13 continuous weeks before the date of injury, report the wages of an employee who has training, experience, skills & wages comparable to the injured employee AND who performs services/tasks comparable in nature and in number of hours. If no similar employee exists, report the limited available wages earned by the injured employee prior to the injury.

NOTE TO INJURED EMPLOYEE - If you were injured on or after 7/1/02, and had employment with more than one employer on the date of injury, you can provide your insurance carrier with wage information from your other employment for the carrier to include in your AWW and this may affect your benefits. Contact your carrier for additional information or call the Division at (800) 252-7031. You can also read rule 122.5 at www.tdi.state.tx.us.

☐ Apprentice: employee who is learning a skilled

trade or art by practical experience under the

direction of a skilled crafts person or artisan.



DIVISION OF WORKERS' COMPENSATION

☐ Trainee: employee undergoing systematic

instruction and practice in some art, trade or

profession with a view towards proficiency in it.

уеаг.

WAGE INFORMATION INSTRUCTIONS

Torres, Sergio

Social Security #: xxx-xx-0096

Nonpecuniary Wages include all wages paid to the employee in a form other than money. These include, but are not limited to, the

Date of Injury: 7/07/09

- The employer shall report all wages earned in the 13 weeks immediately preceding the date of injury. If the employee is paid on a monthly or semi-monthly basis, the employer may provide wages for the 3 months preceding the date of injury. Monthly wages may also be converted to weekly wages by dividing the gross monthly amount by 4.34821. If the employee is paid on a biweekly basis, the employer may provide the wages for the 14 weeks preceding the date of injury. When setting the periods to report, the employer may adjust the reporting period backward slightly (up to six days) to line up the reporting timeframes with the employer's natural pay cycle. However, the employer shall not report wages earned on or after the date of injury.
- If reporting weekly earnings, use all 13 Period Columns below. If reporting 3 months of earnings, either convert the wages to weekly earnings or use the first 3 Period Columns. If reporting 14 weeks of biweekly earnings, use the first 7 Period Columns. In all cases, indicate the dates that each period covers.

| PECUNIARY WAGE I | NFORMA | ATION | | hourly, we commission commission use of the | ekly, biweel ons. Earning ons) need to employee's | kly, monthly gs are repo be prorated equipment | , etc. wage: rted in the . Pecuniary or for paying | s; salary; tip periods the wages don g helpers or | s/gratuities; y are earne t include pa to reimburs | piecework d, NOT who yments mad e for travel o | compensation they are they are they are they an emperson they an emperson to the compenses. | on; monetar paid and s ployer to rei Consider as | y allowances ome (such a nburse the e | e not limited to: s; bonuses; and as bonuses and employee for the counts from paid not used. |
|---|---------|-------|-------|---|--|---|---|--|---|---|---|---|---|--|
| PERIOD # (Week #, Month #, or Bi-Week #) | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | |
| FROM DATE: | 4/05 | 4/12 | 4/19 | 4/26 | 5/03 | 5/10 | 5/17 | 5/24 | 5/31 | 6/07 | 6/14 | 6/21 | 6/28 | |
| TO DATE: | 4/11 | 4/18 | 4/25 | 5/02 | 5/09 | 5/16 | 5/23 | 5/30 | 6/09 | 6/13 | 6/20 | 6/27 | 7/04 | TOTALS |
| # HOURS WORKED: | 49.18 | 49.10 | 54.35 | 63.07 | 58.25 | 54.20 | 51.17 | 55.28 | 62.04 | 55.32 | 68.05 | 50.14 | 57.18 | 727.33 |
| GROSS WAGES EARNED: | (b) (4) | | | | , | | , | | | | | | | |

| NONPECU | NIAR | ey av | VAGE | | | | benefits | listed belo | w but do r | ot include | monetary | allowance | s or stiper | nds paid to | allow the | employe | e to purcha | se the b | enefits. |
|---------------------------|----------|-------|--------------------------------|--------|-----------|----------|----------|-------------|------------|------------------------|----------|-----------|-------------|--------------------|------------|---------|---------------------------|----------|---|
| Nonpecuniary Wage Type | Pro | vide | oyer d Prior ury? | Sp | ecify Val | ue Or Aı | nount Ea | | | ported Pe e periods | | | enefit Pro | ovided P | rior To Ir | njury | Will Em Contin Prov | ue To | Date Benefit Suspended (if suspended) |
| | YE | s | NO 📶 | 2) (4) | 2 | 2 | 4 | 5 | 6 | 7 | O | ٥ | 10 | 11 | 12 | 13 | YES | NO | _ |
| Health Insurance | V | | , | 0) (4) | | | | | | | | | | | | | 0000 | / | 7/3/09 |
| Laundry/ Cleaning | N | A | | | | | | | | | |] | | | . " | | | | |
| Clothing/ Uniforms | N | A | | | | | | | | | | | | | | | | | |
| Lodging/ Housing/ | N | Á | | | | | | | | | | | | | | | | | |
| Food/ Meals | J | A | | | | | | | | | | | | | | | | | |
| Vehicle/ Fuel | M | 4 | | | | | | | | | | | | | | | | | |
| Other | Y | 7 | | | | | | | | | | | | | | | | | |



7/13/2009 8:58 ^ Adjusted Value

Employee Timecard Report

CES Environmental Services, Inc. 7/5/2009 - 7/11/2009

? Exception

* Tardy ~ Holiday Punch

+ Added Item

Badge: 142 ID:0059

HTO - Hours Toward Weekly Overtime

| Torres, Sergio | (Tankwash) |
|----------------|------------|
| | 1 |

< Previous Pay Period Punch

{ Previous Day Punch

| ' | , | | | | | | | _ | |
|---------------|-----------------|-----------|------------|-------|------------|------------|--------|--------------|-----|
| Date | ln | Out | In | Out | Total | Overtime | HTO A | proved By No | tes |
| 7/5/2009 Sun | None | | | | 0:00 | 0:00 | 0:00 | 0:00 | |
| 7/6/2009 Mon | 7:09 | 12:31 | 13:00 | 18:51 | 11:13 | 0:00 | 11:13 | 0:00 | |
| 7/7/2009 Tue | 7:22 | 12:37 | 13:04 | ?_ | ?5:15 | ? | ?!6:28 | 0:00 | |
| 7/8/2009 Wed | 7 :29 | 17:00 | | | 9:31 | 0:00 | ?25:59 | 0:00 | |
| 7/9/2009 Thu | 7:36 | 12:26 | 12:49 | 17:54 | 9:55 | 0:00 | ?35:54 | 0:00 | |
| 7/10/2009 Fri | 7:41 | 17:03 | | | 9:22 | 5:16 | ?45:16 | 0:00 | |
| 7/11/2009 Sat | None | | | | 0:00 | 0:00 | ?45:16 | 00:0 | |
| Department | Reg | <u>0T</u> | <u>Vac</u> | Sick | <u>Hol</u> | <u>Per</u> | Other | <u>Total</u> | |
| Tankwash | ?40:00 | ?5:16 | ?0:00 | ?0:00 | ?0:00 | ?0:00 | ?0:00 | ?45:16 | |
| Totals | -2 40:00 | 25.16 | 70:00 | 70:00 | 70:00 | 70:00 | 70:00 | 245.16 | |
| | | 912 | | | | | | 11912 | |

49:12

Employee Signature

Date

Approved By

7/13/09

Notes:

None Listed

<u>Date</u>

Editor

1700fm

<u>Text</u>

Employee - You are required to report your injury to your employer has workers' compensation insurance. You have the right to assistance from the Texas Department of Insurance, Division of Workers' Compensation and may be entitled to certain medical and income benefits. For further information call your local Division field office or 1(800)-252-7031.



Empleado - Ea necesario que en empleo en lesión a su empleador dentro de 30 días a partir de la focha en que se lesionó si es que su empleo uceta con un seguno de compensación para trabajadores. Usted tiene derecho a recibir asistema guenta por parte de la División de Compensación para Trabajadores, y también puede tener derecho a cieros beneficios médicos y monetarios. Para mayor información comuniquese con la oficina local de la División al teléfono 1-800-252-7031.

| 2. TEXAS WORKERS' C | OMPENSATION WORK ST | ATUS REPORT 👡 | |
|---|---|---------------------------------|--|
| PART I: GENERAL INFORMATIO | 5. Socior's Name and Deg | "Sied nul" | transmission purposes only) Date Being Sent, 1/20/05 |
| Injured Employee's Name TORRES, SERGIO | 6. Clinic/Facility Name . Allied Medical C | enter 9. | Employer's Name CES ENVIROMENTAL |
| 2. Date of Injury 3 Social Security 7/7/2009 XXX-XX-(b) | 7. Clinic/Fecility/Doctor Ph (713) 450-2838(713) | one & Fax 10: | Employer's Fax # or Email Address (if known) |
| Employee's Description of Injury/Accident | 8. Clinic/Facility/Doctor Ad- | dress (street address) 11. | Insurance Carrier |
| Explosion -fe | City State | Zip 12. | Carrier's Fax # or Email Address (if known) |
| | Houston TX, 7 | | 512-224-3889 |
| | | | ND DESCRIPTION IN 13(c) AS APPLICABLE) |
| 13. The injured employee's medical (a) will allow the employee to re | | | |
| (b) will allow the employee to re | eturn to work as of (d | | tified in PART III, which are |
| expected to last through (c) has prevented and still prevented to last through | | 1/20/0 | e) and is expected to continue |
| | ollowing describes how this injury | prevents the employee from | returning to work: |
| DART III. ACTIVITY DESTRICTION | ONC* (ONLY COMPLETE IF DOX | 128 LIC CHECKEN | |
| PART III: ACTIVITY RESTRICTION 14. POSTURE RESTRICTIONS (If any | | TRICTIONS (if any): | 19. MISC. RESTRICTIONS (if any): |
| Max Hours per day: 0 2 4 6 8 0 | Other Max Hours per day | y: 02468 Other | ☐ Max hours per day of work: |
| Standing | Walking | 0000 | ☐ Sit/Stretch breaks ofper |
| Sitting 🗆 🗆 🗎 🗎 | Climb stairs/ledder | s 00 0 0 | ☐ Must wear splint/cast at work |
| Kneeling/Squatting | Gresp/Squeeze | | Must use crutches at all times |
| Bending/Stooping 🗆 🗆 🗎 🗎 | Wrist flex/extension | | ☐ No driving/operating heavy equipment |
| Pushing/Pulling | Reaching Overhead Reaching | | ☐ Can only drive automatic transmission ☐ No work / ☐ ——hours/day work: |
| Other: | Keyboarding | | in extreme hot/cold environments |
| 15. RESTRICTIONS SPECIFIC TO (if | | | ☐ at heights or on scaffolding |
| ☐ L Hand/Wrist ☐ R Hand/Wri | ist 18. LIPT/CARRY F | RESTRICTIONS (if any): | ☐ Must keep: |
| □ LArm □ RArm | ☐ Neck ☐ May not lift/carr | y objects more thanlbs. | ☐ Elevated ☐ Clean & Dry |
| Liteg Riteg | <i>-</i> | hours per day | ☐ No skin contact with: |
| ☐ L Foot/Ankle ☐ R Foot/Ank | " | n any lifting/carrying | ☐ Dressing changes necessary at work |
| Other: 16. OTHER RESTRICTIONS (if any): | Other. | | No Running 20. MEDICATION RESTRICTIONS (if any): |
| | | | ☐ Must take prescription medication(s) |
| | | | Advised to take over-the-counter meds |
| * These restrictions are based on the doct particular restriction does not apply, it shou | | | ☐ Medication may make drowsy |
| available, the patient should be considered to as well as at work. | | | (possible safety/driving issues) |
| PART IV: TREATMENT/FOLLOW | LID ADDOINTMENT INFORM | ATION | |
| 21. Work Injury Diagnosis Informatio | | ervices include: | ph lag |
| 1-C-SPIST | Evaluation by the treating | g doctor on [MUS | 8100 (date) at 0 30 am/pm |
| 21-50/St | Referral to/Consult with | 71 | n(date) at : am/pm |
| 2 BIL W STSP | Physical medicine 2X | COCHET IN HA | |
| 4 BIL Knee P | Special studies (list): X | checkled visit for this problem | on (date) at :am/pm At this time, no further medical care is anticipated. |
| Date / Time of Visit EMPLOYEE'S SIG | DATURE DOCTOR'S SIG | | |
| Discharge Time 500 | HIZA | Initla | Designated doctor Referral doctor |
| Discussing sine | | Follo | Ow-up Carrier-selected RME Consulting doctor |
| I . | | A-100 | MT |



07/22/2009

C E S ENVIRONMENTAL SERVICES I 4904 GRIGGS RD HOUSTON TX 77021-3208 jacosta@cesenvironmental.com

Notification Confirming Receipt of Claim

Date of Injury:

07/07/2009

Injured Worker: Claim Number:

TORRES, SERGIO

0001086044

Policy Number:

Attached is a copy of the information you reported to Texas Mutual Insurance Company which was used to establish this claim. You may submit additional claim information to Texas Mutual Insurance Company. If you have questions regarding this report of injury please contact us at (800) 859-5995.

If your policy includes our workers' compensation health care network option you are required by law to obtain a second Employee Acknowledgement of Workers' Compensation Network Form signed by the injured worker. Please submit a copy of the signed, second acknowledgement form to Texas Mutual Insurance Company. You can find a copy of the form online at www.texasmutual.com/hcn/hcn.shtm

Below please find information that will help you through the claim process:

To submit additional claim information:

To locate a treating doctor:

Mail to: P. O. Box 12029 Austin, Texas 78711-2029 www.texasmutual.com/workers/iwADL.shtm

Fax to: (512) 224-3889

To contact the handling adjuster:

Call: (800) 859-5995

Monday - Friday; 8:00 a.m. - 5:30 p.m.

To obtain a copy of the Employer and Employee Rights and Responsibilities in the

Workers' Compensation System:

www.texasmutual.com/employers/crRights.shtm

To locate a pharmacy, or for pharmacy questions, contact Scripnet:

Call: (888) 880-8562 www.scripnet.com

To obtain a copy of the Employer and Employee Rights and Responsibilities for the workers' comp health care network:

www.texasmutual.com/hcn/hcn.shtm

Additional Texas Mutual® online services at www.texasmutual.com, available 6 a.m. - 9 p.m., include:

- o Obtain logon id, or for immediate logon id, call (800) 859-5995, M-F, 8:00 a.m. 5:30 p.m.
- o Submit first report of injury in the Employers section
- o Submit wage statement when reviewing loss runs and claim details
- Obtain specific claim summary information



Claim Number: 99K000057565303

Notification Date: 07/22/2009

EMPLOYER'S FIRST REPORT OF INJURY

INJURED EMPLOYEE **BUSINESS/EMPLOYER** SERGIO TORRES Name: CESENVIRONMENTAL SERVICES I Name: SSN: XXX-XX(b) Address: Mailing 4904 GRIGGS RD HOUSTON TX 77021-3208 Address: **Phone:** (713)676-1460 Ext: Fax: (713)676-1676 County: Policy Number: 0001086044 Physical Address 760592985 FEIN: Location ID: County: **EMPLOYMENT** Home Phone: Occupation: Date of Birth: Hire Date: State: TX Marital Status: Not Married Partner/Officer/Owner: Gender: Dependents: 01 Male Date Lost Time Began: 00/00/0000 Language: Return to Work Date: English 00/00/0000 Last Paycbeck was: MEDICAL PROVIDER Wage: Frequency: Name: ALLIED MEDICAL CENTER Hours/Week: Days/Week: Tax ID: Period Start: 00/00/0000 Period End: 00/00/0000 Address: 11430 I10 E FWY STE 350 HOUSTON TX 77029 Supervisor Name: JAMES PHARMS Phone: Ext: Fax: Phone: (713)450-2838 PREPARER OF REPORT **ATTORNEY** Name: JOSE ACOSTA Represented by Attorney: **Phone:** (713)676-1460 Fax: (713)676-1676 Name: Email: jacosta@cesenvironmental.com Phone: **INJURY INFORMATION** Date of Injury: Time: 16:00 Address Where Injury Occurred: 07/07/2009 4904 GRIGGS RD Date Reported: 00/00/0000 HOUSTON TX 77021-3208 Nature of Injury: SPRAIN County: HARRIS Witnesses: Cause of Injury: STRUCK Name: BY/INJURED-EXPLOSION OR Phone: FLARE BACK Name: MULTIPLE BODY Part of Body: Phone: PARTS(INCL.BODY SYSTEMS & BDY PARTS Name: Fatality: Phone:

How and Why the Injury/Illness Occurred

CERVICAL SPRAIN/STRAIN. LUMBAR SPRAIN/STRIAN. BILATERAL WRIST SPRAIN. BILATERAL KNEE SPRAIN. DETAILS ARE UNKNOWN.



| CLAIM# | (b) (4) | |
|-----------|-------------|--|
| Carrier # | | |
| | | |

SUPPLEMENTAL REPORT OF INJURY

| 1. Employer business name CES Environmental Services 3. Employer mailing address 4904 Griggs Rd 4. Insurance carrier name Texas Mutual 5. Does the employer have return to work (RTW) opportunities available based on the injured worker's current capabilities? yes no if so, identify contact person and phone # 6. Has the insurance carrier provided RTW coordination services within the past 12 months? yes Date no / 7. Has the employer requested RTW training from DWC or the insurance carrier? yes no / 8. Has the insurance carrier provided accident prevention services in the past 12 months? yes Date no / 9. Has the employer requested accident prevention services in the past 12 months? yes Date no / 9. Has the employer requested accident prevention services in the past 12 months? yes Date no / 9. Has the employer requested accident prevention services in the past 12 months? yes Date no / 9. Has the employer requested accident prevention services in the past 12 months? yes Date no / 9. 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|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
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DWC FORM-6 (Rev. 10/05) Page I

DIVISION OF WORKERS' COMPENSATION

DWC FORM-6 Supplemental Report of Injury

DWC requires the reporting of all Return to Work and Post-Injury Change of Earnings. An injured worker is entitled to temporary income benefits if he/she has disability (defined as the inability to work, or the inability to earn wages equivalent to pre-injury wages, as a result of the injury) and has not reached maximum medical improvement (defined as having reached 104 weeks from the eighth day of lost time or when a doctor certifies that no further recovery can be reasonably anticipated). The insurance carrier shall adjust the weekly amount of temporary income benefits paid to the injured worker to match the fluctuations in weekly earnings after the injury. To ensure the insurance carrier has accurate information to calculate benefits, the DWC FORM-6 is to be completed as applicable:

By EMPLOYER By INJURED WORKER The EMPLOYER means the employer for whom the injured worker was If you (the INJURED WORKER) are no longer employed by the working when the injury occurred. If the employer is the current employer, employer where the injury/ifiness occurred, then you are then you are responsible to provide information to the workers' compensation responsible to provide information to the workers' compensation insurance carrier about: insurance carrier about: The existence of earnings, and The existence of earnings, and The amount of any earnings, or The amount of any carnings, or Any offers of employment. Any offers of employment. Include CLAIM and insurance carrier numbers in right upper hand corner, This form may be used to do so. Include CLAIM and insurance Complete items 1-21, sign and date. carrier numbers in right upper hand corner. Complete items 1-4, 10-21, sign and date. The EMPLOYER must file this form: If you are employed by a new employer after the injury; and For a worker's injury/illness that occurs after January 1, 1991 and required the previous filing of a DWC FORM-1, Employer's You are receiving benefits, you must tell the insurance First Report of Injury; and carrier if your wages change, regardless of whether your During the time the injured worker is entitled to temporary income went up or down; or income benefits (TIBs); and You are not receiving benefits, you must tell the Until the injured worker: > Reaches maximum medical improvement (MMI), or insurance carrier if the injury causes you to miss work or > Is no longer employed by the employer. lose income.

his report must be filed in the following situations within the timeframes indicated:

- 3 days after the injured worker begins to lose time from work as a result of the injury, if lost time did not occur immediately following the injury;
- 3 days after the injured worker returns to work:
- 3 days, when the injured worker returned to work, then later has additional day(s) of lost time as a result of the injury;
- 10 days after the end of each pay period in which the injured worker has a change in earnings as a result of the injury;
- 10 days after the injured worker resigns or is terminated.

White most of the sections on this form are self-explanatory, please note that the pay periods requested in sections 20 & 21 may be different depending on the situation for which the form is being filed:

- If the report is indicating lost time from work or the end of employment, the pay period shall be the most recent pay period prior to the lost time.
- If the report is indicating return to work or a change in earnings, the pay period shall be the pay period the injured worker is beginning.

This form is to be fited by first class mail or personal delivery with:

- The insurance carrier, and
- The injured worker,

This report is considered filed when personally delivered or postmarked.

This form is to be filed by first class mail or personal delivery with:

· The insurance carrier.

This report is considered filed when personally delivered or postmarked.

If you return to work for the same employer or a different employer, your temporary income benefits from the insurance carrier must be adjusted.

Failure to report earned wages and/or offers of employment to the insurance carrier who is paying henefits to you is a crime that may result in fines and/or imprisonment.

Failure to comply with these filing requirements, without good cause, is a Class D administrative violation, subject to a penalty not to exceed \$500.

TLC§ 409.005 and Rules 120.3 and 129.4 provide the requirements regarding use of this report. The complete rule text is available on the DWC website at: www.tdi.state.tx.us



DWC FORM-6 (Rev. 10/05) Page 2

DIVISION OF WORKERS' COMPENSATION

7/21/2009 7:28

{ Previous Day Punch

Employee Timecard Report

^ Adjusted Value CES Environmental Services, Inc. < Previous Pay Period Punch

7/12/2009 - 7/18/2009

? Exception

+ Added Item

* Tardy

~ Holiday Punch

Torres, Sergio (Tankwash)

HTO - Hours Toward Weekly Overtime

| Torres, Sergio | (<mark>Tankwash</mark>) | | * | | 1 m - 1 m - 1 m | and the second | | Badge: 142 ID:00 | 059 |
|----------------|---------------------------|-----------|------------|-------------|-----------------|----------------|--------------|------------------|------|
| Date | ln | Out | ln' | Out | Total | Overtime | HTO Ap | proved By: No | otes |
| 7/12/2009 Sun | None | | | | 0:00 | 0:00 | 0:00 | 0:00 | |
| 7/13/2009 Mon | 9:04 | 19:00 | | | 9:56 | 0:00 | 9:56 | 0:00 | |
| 7/14/2009 Tue | 8:25 | 12:08 | 12:35 | 20:40 | 11:48 | 0:00 | 21:44 | 0:00 | |
| 7/15/2009 Wed | 8:11 | 18:00 | | | 9:49 | 0:00 | 31:33 | 0:00 | |
| 7/16/2009 Thu | 7:00 | 18:21 | | | 11:21 | 2:54 | 42:54 | 0:00 | |
| 7/17/2009 Fri | 8:11 | ? | | | 7 | ? | ?42:54 | 0:00 | |
| 7/18/2009 Sat | None | | | | 0:00 | 0:00 | ?42:54 | 0:00 | |
| Department | Reg | <u>0T</u> | <u>Vac</u> | <u>Sick</u> | Hol | <u>Per</u> | <u>Other</u> | <u>Total</u> | |
| Tankwash | ?40:00 | ?2:54 | ?0:00 | 70:00 | ?0:00 | ?0:00 | ?0:00 | ?42:54 | |
| Totals | 3 40:00 | 22:54 | ?0:00 | ?0:00 | ?0:00 | ?0:00 | ?0:00 | 342:54 | |
| | • | 813 | | | | | | 4813 | |
| | | | 4 | 18:13 | \supset | | | 10 . | |

Employee-Signature

Approved By

Notes:

<u>Date</u> None Listed <u>Editor</u>

<u>Text</u>

Date

Fri 13:00 - 13:30 - 17:00

-3hrs Ludch

Employee - You are required to report your injury to your employer within 30 days if your employer has workers' compensation insurance. You have the right to free assistance from the Texas Department of Insurance, Division of Workers' Compensation and may be entitled to certain medical and income benefits. For further information call your local Division field office or i(800)-252-7031.



Empleado - Es necesario que reporte su lesión a su empleador dentro de 30 días a partir de la fecha en que se lesionó si es que su empleador cuenta con un seguro de compensación para trabajadores. Usted tiene derecho a recibir asistencia gramita por parte de la División de Compensación para Trabajadores, y también puede tener derecho a ciertos beneficios médicos y manetarios. Para mayor información comuniquese con la oficina local de la División al teléfono 1-800-252-7031.

| 2. TEXAS WORKERS' COMPENSA | TION WORK STATUS REPORT — | _ | | | | |
|--|--|---|-------------------|--|--|--|
| PARTI: GENERAL INFORMATION | Sharia Suea. Mi | (for transmission purposes only) | Date Being Sent | | | |
| 1. Injured Employee's Name TORRES, SERGIO | Clinic/Facility Name Allied Medical Center | 9. Employer's Name CES ENVIROMENTAL | | | | |
| 2. Date of Injury 3. Social 7.7/2009 XXX-X | Clintc/Facility/Doctor Phone & Fax (713) 450-2838(713) 450-2843 | 10. Employer's Fax # or Email Address (| f known) 676 | | | |
| 4. Employee's Description of Injury/Accident 8. | 11430 l- 10 East Frwy., Ste 350 | 11. Insurance Carrier UX45 Mut | ral | | | |
| of toster for | ty Slate Zip Houston TX, 77029 | 12. Carrier's Fax # or Email Address (If k 512 - 224 - 38 | 185 | | | |
| PART II: WORK STATUS INFORMATION (FU | LLY COMPLETE ONE INCLUDING ESTIMATED DATE | S AND DESCRIPTION IN 13(c) AS A | PPLICABLE) | | | |
| 13. The injured employee's medical condition res | ulting from the workers' compensation injury: | , | | | | |
| 1 | as of (date) with the restrictions id | lentified in PART III, which are | · | | | |
| expected to last through (date). | ω | daye) and is expected to continu | | | | |
| (date). The following description | oyee from returning to work as of | dage) and is expected to continuous returning to work: | Je | | | |
| , | | | | | | |
| PART III: ACTIVITY RESTRICTIONS* (ONLY 14. POSTURE RESTRICTIONS (If any): | 17. MOTION RESTRICTIONS (if any): | 19. MISC. RESTRICTIONS | (if any): | | | |
| Max Hours per day: 0 2 4 6 8 Other | Max Hours per day: 0 2 4 6 8 Other | Max hours per day of wor | | | | |
| Standing 🗀 🗆 🗆 | Walking | Sit/Stretch breake of | | | | |
| Sitting | Climb stairs/ladders | ☐ Must wear splint/cast at w | | | | |
| Kneeling/Squatting | Grasp/Squeeze | Must use crutches at all ti | mes | | | |
| Bending/Stooping | Wrist flex/extension [] [] [] | No driving/operating heav | * * * | | | |
| Pushing/Pulling | Reaching | Can only drive automatic | | | | |
| Twisting | Overhead Reaching | □ No work / □ — hou □ in extreme hot/cold e | irs/day work: | | | |
| 15. RESTRICTIONS SPECIFIC TO (if applicable): | Other: | at heights or on scaff | | | | |
| L Hand/Wrist R Hand/Wrist | 18. LIFT/CARRY RESTRICTIONS (if any): | ☐ Must keep | | | | |
| LArm RArm Neck | May not lift/carry objects more thanlbs | | an & Dry | | | |
| ☐ Lleg ☐ Rleg ☐ Back | for more than hours per day | ☐ No skin contact with: | | | | |
| ☐ L Foot/Ankle ☐ R Foot/Ankle | ☐ May not perform any lifting/carrying | ☐ Dressing changes necess | sary at work | | | |
| 16. OTHER RESTRICTIONS (if any): | Other: | No Running 20. MEDICATION RESTRIC | DONS (if any): | | | |
| 10. OTHER RESTRICTIONS IN any). | | Must take prescription me | | | | |
| | | Advised to take over-the- | counter meds | | | |
| * These restrictions are based on the doctor's best under | | a | | | | |
| particular restriction does not apply, it should be disregarded. If modified duty that meets these restrictions is not available, the patient should be considered to be off work. Note - these restrictions should be followed outside of work (possible safety/driving issues) as well as at work. | | | | | | |
| | | | | | | |
| PART IV: TREATMENT/FOLLOW-UP APPOI 21. Work Injury Diagnosis Information: 22 Ex | pected Follow-up Services Include: | | | | | |
| | aluation by the treating doctor on [MC | S XIVO Tuate) at [0 | .30am/pm | | | |
| 71 - 50/C+ Re | ferral to/Consult with MLK | on (date) at | :am/pm | | | |
| I a POLL LAN BESPORT | ysical medicine X per week for Tweeks starti | ng on (date) at | :am/pm | | | |
| | ecial studies (list): XLLLYS/ W.L. | on(date) at | ; am/pm | | | |
| Date / Time of Visit EMPLOYEE'S SIGNATURE | ne. This is the last scheduled visit for this problem DOCTOR'S SIGNATURE Visit | Type: Role of Doctor: | Treating doctor | | | |
| 9120109 Say à Tos | 1 | itial Designated doctor | Referral doctor | | | |
| Discharge Time | Charles II | ofference | Consulting doctor | | | |
| | for dec | ☐ TWCC-selected RME | Other doctor | | | |

Jose Encinia
Claim #



07/22/2009

C E S ENVIRONMENTAL SERVICES I 4904 GRIGGS RD HOUSTON TX 77021-3208

Notification Confirming Receipt of Claim

Date of Injury:

07/07/2009

Injured Worker:

ENCINIA, JOSE ANTONIO

Claim Number:

b) (4)

Policy Number:

0001086044

Attached is a copy of the information you reported to Texas Mutual Insurance Company which was used to establish this claim. You may submit additional claim information to Texas Mutual Insurance Company. If you have questions regarding this report of injury please contact us at (800) 859-5995.

If your policy includes our workers' compensation health care network option you are required by law to obtain a second Employee Acknowledgement of Workers' Compensation Network Form signed by the injured worker. Please submit a copy of the signed, second acknowledgement form to Texas Mutual Insurance Company. You can find a copy of the form online at www.texasmutual.com/hcn/shtm

Below please find information that will help you through the claim process:

To submit additional claim information:

To locate a treating doctor:

Mail to: P. O. Box 12029 Austin, Texas 78711-2029

Fax to: (512) 224-3889

www.texasmutual.com/workers/iwADL,shtm

To contact the handling adjuster:

Call: (800) 859-5995

Monday - Friday; 8:00 a.m. - 5:30 p.m.

To obtain a copy of the Employer and Employee Rights and Responsibilities in the

Workers' Compensation System:

www.texasmutual.com/employers/erRights.shtm

To locate a pharmacy, or for pharmacy questions, contact Scripnet:

Call: (888) 880-8562 www.scripnet.com To obtain a copy of the Employer and Employee Rights and Responsibilities for the workers' comp health care network:

www.texasmutual.com/hcn/hcn.shtm

Additional Texas Mutual® online services at www.texasmutual.com, available 6 a.m. - 9 p.m., include:

- o Obtain logon id, or for immediate logon id, call (800) 859-5995, M-F, 8:00 a.m. 5:30 p.m.
- o Submit first report of injury in the Employers section
- o Submit wage statement when reviewing loss runs and claim details
- Obtain specific claim summary information



Claim Number: (b) (4)

Notification Date: 07/22/2009

EMPLOYER'S FIRST REPORT OF INJURY

INJURED EMPLOYEE BUSINESS/EMPLOYER Name: JOSE ANTONIO ENCINIA Name: C E S ENVIRONMENTAL SERVICES 1 SSN: XXX-XX-(b) Address: Mailing 4904 GRIGGS RD HOUSTON TX 77021-3208 Address: **Phone:** (713)676-1460 **Ext:** Fax: (713)676-1676 County (b) (4) **Policy Number:** 0001086044 Physical Address: FEIN: 760592985 Location ID: County: (b) (4) **EMPLOYMENT** Home Phone: Occupation: <u>TECHNICLAN</u> Date of Birth: (b) Hire Date: (b) (4) State: TX Marital Status. Married Partner/Officer/Owner: No Gender: Dependents: 00 Male Date Lost Time Began: 00/00/0000 Language: Return to Work Date: English 00/00/0000 Last Paycheck was: MEDICAL PROVIDER Wage: Frequency: Name: ALLIED MEDICAL CENTER Hours/Week: Days/Week: Tax ID: Period Start: 00/00/0000 Period End: 00/00/0000 Address: 11430 110 E FWY STE 350 Supervisor HOUSTON TX 77029 Name: JAMES PHARMS Phone: Ext: Phone: (713)450-2838 Fax: PREPARER OF REPORT **ATTORNEY** Name: JOSE ACOSTA Represented by Attorney: Phone: (713)676-1460 Ext: Fax:(713)676-1676 Name: Email: Phone: INJURY INFORMATION Date of Injury: 07/07/2009 Time: 16:00 Address Where Injury Occurred: 4904 GRIGGS RD **Date Reported:** 00/00/0000 HOUSTON TX 77021-3208 Nature of Injury: SPRAIN County: HARRIS Witnesses: Cause of Injury: STRUCK Name:

Phone:

Phone:

Phone:

Name:

Name:

How and Why the Injury/Illness Occurred

Part of Body:

Fatality:

FLARE BACK

MULTIPLE BODY

PARTS(INCL.BODY SYSTEMS & BDY PARTS

BY/INJURED-EXPLOSION OR

BILATERAL HAND SPRAIN/STRAIN. BILATERAL WRIST SPRAIN/STRAIN. LUMBAR SPRAIN/STRAIN. BILATERAL KNEE SPRAIN/STRAIN. HE WAS CLIMBING DOWN LADDER A 4FT LADDER AND FELL.

Send to workers' compensation carrier:

Texas Mutual 713-316-2191

(Name and fax number of carrier)



| CLAIM#_ | 99K000057565304 | |
|----------|-----------------|--|
| _ | | |
| CARRIER' | S CLAIM# | |

☐ Initial ☐ Amended

Employee's Name (Last, First, M.I.):

EMPLOYER'S WAGE STATEMENT

The Texas Workers' Compensation Act and Workers' Compensation rules require an employer to provide an Employer's Wage Statement to its workers' compensation insurance carrier (carrier) and the claimant or the claimant's representative, if any. The purpose of the form is to provide the employee's wage information to the carrier for calculating the employee's Average Weekly Wage (AWW) to establish benefits due to the employee or a beneficiary.

The AWW is based on the wages the employee earned in the 13 weeks immediately preceding the date of injury (or the wage a similar employee earned if the employee did not work the full 13-week period). "Wages" include all forms of remuneration payable to an employee for personal services, including fringe benefits. To simplify filing, employers may file wages in a monthly, biweekly, or weekly manner as discussed below.

NOTE - An employer who fails without good cause to timely file a complete wage statement as required by the Texas Workers' Compensation Act, Texas Labor Code, Section 408.063(c) and Worker's Compensation Rule 120.4 may be assessed an administrative penalty not to exceed \$500.00 for an initial offense and not to exceed \$10,000.00 for a repeated administrative violation.

EMPLOYEE AND EMPLOYER INFORMATION

The employer shall timely file a complete wage statement in the form and manner prescribed by the Division.

- (1) The wage statement shall be filed ("filed" means received) with the carrier, the claimant, and the claimant's representative (if any) within 30 days of the earliest of:
 - (A) the employee's eighth day of disability;

Employer's Business Name:

- (B) the date the employer is notified that the employee is entitled to income benefits;
- (C) the date of the employee's death as a result of a compensable injury.
- (2) The wage statement shall also be filed with the Division within seven days of receiving a request from the Division (Only When Requested).
- (3) A subsequent wage statement shall be filed with the carrier, employee, and the employee's representative (if any) within seven days if any information contained on the previous wage statement changes (such as if the employer discontinues providing a nonpecuniary wage that was initially continued after the date of injury).

All applicable DWC rules can be found at www.tdi.state.tx.us

| Encinia, Jose | | CES Environmental Services, In | | | | | |
|---|-------------------------------|--|------------------------|--|--|--|--|
| Employee's Mailing Address (Street or P.O. Box): | | Employer's Mailing Address (Street or P.O. Box): | | | | | |
| (b) (4) | | 4904 Griggs Ro | | | | | |
| | 7IP Code: | City: | State: | ZIP Code: | | | |
| (b) (4) | | Houston | TX | 77021 | | | |
| Social Security (ast four digits): | | Federal Tax I.D. Number: | 7 | | | | |
| XXX-XX | | 76-0592985 | | | | | |
| Date of Hire: Date of Injur | y: | Name and Phone # of Per | son Providing Wage I | nformation: | | | |
| (b) (4) 7/07/09 |) | Jose Acosta | | | | | |
| ☐ As of today's date, the employee is not back | at work. OR | | | | | | |
| ☑ The employee returned to work on | and is working: | | | nt is complete, accurate, and | | | |
| ☑ without restriction. OR | | | | ion Act and applicable rules, | | | |
| ☐ with restrictions and is earning wages of | \$ per | and the listed wages include all pecuniary and nonpecuniary wages paid for (earned in) the 13 weeks prior to the date of injury (as described on page 2) | | | | | |
| week/month (circle one). | | and I understand that making a misrepresentation about a workers' | | | | | |
| NOTE - Rule 120.3 requires the employer file the | | compensation claim is a c | ime that can result in | fines and/or imprisonment. | | | |
| Injury (DWC FORM-6) to report changes in Work Earnings. | Status and Post-Injury | Signature: | | Date: | | | |
| | | <u> </u> | | | | | |
| EMPLOYMENT STATUS AT TIME OF | INJURY (Check A | III That Apply) | | | | | |
| ☑ Full-time: employee who regularly works at | | r Course of Conduct: | | ee less than 18 years of age | | | |
| least 30 hours per week and whose schedule is | | history for the 12-month and not emancipated by marriage or judicial | | | | | |
| comparable to other employees of the company and/or other employees in the same business or | worked part-time during the | ary shows the person only action who is also an apprentice, trainee or hat period. | | | | | |
| vicinity who are considered full-time. | | ular Course of Conduct: | · | | | | |
| , | | history for the 12-month study in high school, college or other institute of | | | | | |
| Seasonal: employee who as regular course of conduct engages in seasonal or cyclical | | ry shows part-time and full | higher education or | technical training. | | | |
| employment that may or may not be agricultural in | time work during that peri | | | | | | |
| nature and that does not continue throughout the | | e who is learning a skilled at experience under the | | oyee undergoing systematic | | | |
| year. | direction of a skilled crafts | • | | d practice in some art, trade or a view towards proficiency in it. | | | |

SAME OR SIMILAR EMPLOYEE?

The wage information on this form is for:

☐ The Injured Employee OR ☑ A Similar Employee (NOTE — If requested by the Division, the employer shall identify the similar employee whose wages were provided.)

If the employee was not employed for 13 continuous weeks before the date of injury, report the wages of an employee who has training, experience, skills & wages comparable to the injured employee AND who performs services/tasks comparable in nature and in number of hours. If no similar employee exists, report the limited available wages earned by the injured employee prior to the injury.

NOTE TO INJURED EMPLOYEE – If you were injured on or after 7/1/02, and had employment with more than one employer on the date of injury, you can provide your insurance carrier with wage information from your other employment for the carrier to include in your AWW and this may affect your benefits. Contact your carrier for additional information or call the Division at (800) 252-7031. You can also read rule 122.5 at www.tdi.state.tx.us.



DIVISION OF WORKERS' COMPENSATION

Nonpecuniary Wages include all wages paid to the employee in a form other than money. These include, but are not limited to, the

- The employer shall report all wages **earned in the 13 weeks immediately preceding the date of injury.** If the employee is paid on a monthly or semi-monthly basis, the employer may provide wages for the 3 months preceding the date of injury. Monthly wages may also be converted to weekly wages by dividing the gross monthly amount by 4.34821. If the employee is paid on a biweekly basis, the employer may provide the wages for the 14 weeks preceding the date of injury. When setting the periods to report, the employer may adjust the reporting period backward slightly (up to six days) to line up the reporting timeframes with the employer's natural pay cycle. **However, the employer shall not report wages earned on or after the date of injury.**
- If reporting weekly earnings, use all 13 Period Columns below. If reporting 3 months of earnings, either convert the wages to weekly earnings or use the first 3 Period Columns. In all cases, indicate the dates that each period covers.

| PECUNIARY WAGE II | | hourly, we commission commission use of the | eekly, biweek ons. Earning ons) need to | kly, monthly, gs are repo be prorated; equipment o | /, etc. wages orted in the p f. Pecuniary or for paying | s; salary; tip periods they wages don' g helpers or | s/gratuities; y are earned t include par to reimburse | piecework of d, NOT whe yments mad e for travel of | compensation they are e by an emperson compensation to the compensation of the compens | n; monetar paid and so ployer to rein Consider as | y allowance: ome (such a mburse the e earnings am | e not limited to: s; bonuses; and as bonuses and employee for the counts from paid not used. | | |
|-----------------------------------|---------|---|---|---|--|--|--|---|--|--|--|---|-------|--------|
| PERIOD # (Week #, | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | |
| Month #, or Bi-Week #) FROM DATE: | 4/05 | 4/12 | 4/19 | 4/26 | 5/03 | 5/10 | 5/17 | 5/24 | 5/31 | 6/07 | 6/14 | 6/21 | 6/28 | |
| TO DATE: | 4/11 | 4/18 | 4/25 | 5/02 | 5/09 | 5/16 | 5/23 | 5/30 | 6/06 | 6/13 | 6/20 | 6/27 | 7/04 | TOTALS |
| # HOURS WORKED: | 33.16 | 47.26 | 48.20 | 52.34 | 44.14 | 49.25 | 44.24 | 49.25 | 43.32 | 55.07 | 50.22 | 52.15 | 63.20 | 631.8 |
| GROSS WAGES EARNED: | (b) (4) | | | | | | | | | | | | | |

| Nonpecuniary Wage Type | Provide | lloyer ed Prior ijury? | Spe | ecify Val | ue Or An | nount Ea | ount Earned in Each Reported Period For Each Benefit Provided Prior To Injury (Use the same periods as used above) | | | | | | | | | Conti | nployer nue To ride? | Date Benefit Suspended (if suspended) |
|---------------------------|---------|------------------------------|-----|-----------|----------|----------|--|---|---|---|---|----|----|----|----|-------|----------------------------|---------------------------------------|
| | YES | NO | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | YES | NO | |
| Health Insurance | 1/12 | | | | | | | | | | | | | | | | | |
| Laundry/ Cleaning | 7/8 | | | | | | | | | | | | | | | | | |
| Clothing/ Uniforms | 4/18 | | | | | | | | | | | | | | | | | |
| Lodging/ Housing/ | NA | | | | | | | | | | | | | | | | | |
| Food/ Meals | AL | | | | | | | | | | | | | | | | | |
| Vehicle/ Fuel | AK | | | | | | | | | | | | | | | | | |
| Other | 4/18 | | | | | | | | | | | | | | | | | |



DWC FORM-3 (Rev. 10/05) Page 2

7/13/2009 8:58

Employee Timecard Report

^ Adjusted Value < Previous Pay Period Punch { Previous Day Punch CES Environmental Services, Inc 7/5/2009 - 7/11/2009

? Exception + Added Item

* Tardy ~ Holiday Punch

HTO - Hours Toward Weekly Overtime

Badge: 123 ID:0006

| Encinia, Jose (Tankwash) | Encinia, Jose | (Tankwash) |
|--------------------------|---------------|------------|
|--------------------------|---------------|------------|

| Date | ln | Out | In | Out | Total | Overtime | нто | Approved By | Notes |
|-------------------|--------|-------------------|------------|-------|------------|------------|--------------|----------------|-------|
| 7/5/2009 Sun | None | | | | 0:00 | 0:00 | 0:00 | 0:00 | |
| 7/6/2009 Mon | 13:53 | 20:43 | 21:09 | 0:06 | 9:47 | 0:00 | 9:47 | 0:00 | |
| 7/7/2009 Tue | 13:56 | 1900 | 1930 | 1300 | ? | ? | ?9:47 | 0:00 | |
| 7/8/2009 Wed | 13:38 | 18:31 | 1900 | 2300 | 4:53 | 0:00 | ?14:40 | 0:00 | |
| 7/9/2009 Thu | 14:04 | 20:42 | 21:36 | 23:17 | 8:19 | 0:00 | ?22:59 | 0:00 | |
| 7/10/2009 Fri | 13:39 | 1900 | 1930 | 2300 | ? | ? | ?22:59 | 0:00 | |
| 7/11/2009 Sat | None | | | | 0:00 | 0:00 | ?22:59 | 0:00 | |
| <u>Department</u> | Reg | <u> </u> | <u>Vac</u> | Sick | <u>Hol</u> | <u>Per</u> | <u>Other</u> | <u>Total</u> | |
| Tankwash | ?22:59 | ?0:00 | ?0:00 | ?0:00 | 70:00 | ?0:00 | ?0:00 | ?22:59 | |
| Totals | 222:59 | ~70:00 | 70:00 | 70:00 | 70:00 | ?0:00 | 70:00 | 722:59 | |
| | 40 | 4:24 | | | | | | ?22:59 44:2 | 4 |
| | | | | | | | | • | |

44:24

Employee Signature

Approved By

Notes:

<u>Date</u>

None Listed

Editor

<u>Text</u>

Date

+ vacation dans



| CLAIM# | 991000057565304 | |
|-----------|-----------------|--|
| Carrier # | | |

SUPPLEMENTAL REPORT OF INJURY

| Part I EMPLOYER INFORMATION | |
|---|--|
| Employer business name | 2. Employer phone # |
| CES Environmental Services | 713-676-1460 |
| Employer mailing address | |
| 4904 Griggs Rd | |
| Insurance carrier name | |
| Texas Mutual | |
| Does the employer have return to work (RTW) opportunit If so, identify contact person and phone # | ties available based on the injured worker's current capabilities? yes no |
| 6. Has the insurance carrier provided RTW coordination services. | vices within the past 12 months? yes Date no 🗸 |
| 7. Has the employer requested RTW training from DWC or t | he insurance carrier? yes no 🗸 |
| 8. Has the insurance carrier provided accident prevention se | ervices in the past 12 months? yes Date no 🗸 |
| Has the employer requested accident prevention services | from the insurance carrier? yes no |
| Part II REASON FOR FILING THIS REPORT (d | leadlines vary, see instructions) |
| 10. a. The injured worker returned to work in either | a full or limited capacity: File this report within 3 days. |
| b. The injured worker is earning more or less tha | an the pre-injury wage because of the injury: File within 10 days. |
| | dditional lost time or reduced wages as a result of the injury: File within 3 days. |
| | , , |
| d. The injured worker resigned or was terminate | a from employment: File within 10 days. |
| Part III INJURED WORKER INFORMATION | 12, SSN (last 4 digits) |
| 11. Injured worker name | (b) (d) |
| Jose Encinia | 7/7/2009 |
| 14. Injured worker mailing address and phone # (b) (4) | |
| 15. First day of lost time or reduced | 16. First day of additional lost time |
| wages for this injury (mm/dd/yyyy) | or reduced wages (mm/dd/yyyy) |
| Has the injured worker experienced 8 days (cumulative) of If yes, the date of the 8th day (mm/dd/yyyy) | of lost time or reduced wages as a result of the injury? yes no |
| 19 Has the ini | ured worker resigned, been terminated or died? yes ✓ no |
| 18. Date of most recent RTW | |
| | ation date of termination 7/22/2009 date of death |
| laid off | |
| | njured worker on limited duty when terminated? |
| 20. Hours the injured worker was working during the pay peri | od of 21. Weekly/hourly earnings for the pay period of +/5/02 rs per week to +/11/02:\$ weekly or \$ (b) (4) ++/2 |
| Indicated hours are: | Indicated wages are: |
| Increase from pre-injury | Increase from pre-injury wage |
| Same as pre-injury | Same a pre-injury wage |
| Decrease from pre-injury | Decrease from pre-injury wage |
| | carrier and the injured worker in the timeframe as noted in Part II. |
| This form to be med with. | in the unit the injured worker in the unieriance as noted in Part in. |
| 22. To the best of my knowledge the information provided in | this report is accurate and may be relied upon for evaluation of eligibility for benefits. |
| Sulamitted by | Injured Worker (If no longer working for the employer where injury occurred.) |
| | |
| A. Ment HSE Mangour | 7-24-09 |
| Signature and Title of person completing this form | Date |
| | |
| | ## #### (|
| | |
| | |
| | |

DWC FORM-6 (Rev. 10/05) Page 1

DIVISION OF WORKERS' COMPENSATION

DWC FORM-6 Supplemental Report of Injury

DWC requires the reporting of all Return to Work and Post-Injury Change of Earnings. An injured worker is entitled to temporary income benefits if he/she has disability (defined as the inability to work, or the inability to earn wages equivalent to pre-injury wages, as a result of the injury) and has not reached maximum medical improvement (defined as having reached 104 weeks from the eighth day of lost time or when a doctor certifies that no further recovery can be reasonably anticipated). The insurance carrier shall adjust the weekly amount of temporary income benefits paid to the injured worker to match the fluctuations in weekly earnings after the injury. To ensure the insurance carrier has accurate information to calculate benefits, the DWC FORM-6 is to be completed as applicable:

| By EMPLOYER | By INJURED WORKER |
|--|---|
| The EMPLOYER means the employer for whom the injured worker was working when the injury occurred. If the employer is the current employer, then you are responsible to provide information to the workers' compensation insurance carrier about: The existence of earnings, and The amount of any carnings, or Any offers of employment. Include CLAIM and insurance carrier numbers in right upper hand corner. Complete items 1-21, sign and date. | If you (the INJURED WORKER) are no longer employed by the employer where the injury/illness occurred, then you are responsible to provide information to the workers' compensation insurance carrier about: The existence of earnings, and The amount of any carnings, or Any offers of employment. This form may be used to do so. Include CLAIM and insurance carrier numbers in right upper hand corner. Complete items 1-4, 10-21, sign and date. |
| The EMPLOYER must file this form: For a worker's injury/illness that occurs after January 1, 1991 and required the previous filing of a DWC FORM-1. Employer's First Report of Injury; and During the time the injured worker is entitled to temporary income benefits (TIBs); and Until the injured worker: Reaches maximum medical improvement (MMI), or Is no longer employed by the employer. | If you are employed by a new employer after the injury; and You are receiving benefits, you must tell the insurance carrier if your wages change, regardless of whether your income went up or down; or You are not receiving benefits, you must tell the insurance carrier if the injury causes you to miss work or lose income. |

his report must be filed in the following situations within the timeframes indicated:

- 3 days after the injured worker begins to lose time from work as a result of the injury, if lost time did not occur immediately following the injury:
- 3 days after the injured worker returns to work;
- 3 days, when the injured worker returned to work, then later has additional day(s) of lost time as a result of the injury;
- 10 days after the end of each pay period in which the injured worker has a change in earnings as a result of the injury;
- 10 days after the injured worker resigns or is terminated.

While most of the sections on this form are self-explanatory, please note that the pay periods requested in sections 20 & 21 may be different depending on the situation for which the form is being filed:

- If the report is indicating lost time from work or the end of employment, the pay period shall be the most recent pay period prior to the lost time.
- If the report is indicating return to work or a change in earnings, the pay period shall be the pay period the injured worker is beginning.

This form is to be filed by first class mail or personal delivery with:

- The insurance carrier, and
- The injured worker.

This report is considered filed when personally delivered or postmarked.

This form is to be filed by first class mail or personal delivery with:

· The insurance carrier.

This report is considered filed when personally delivered or postmarked.

If you return to work for the same employer or a different employer, your temporary income benefits from the insurance carrier must be adjusted.

Failure to report earned wages and/or offers of employment to the insurance carrier who is paying benefits to you is a crime that may result in fines and/or imprisonment.

Failure to comply with these filing requirements, without good cause, is a Class D administrative violation, subject to a penalty not to exceed \$500.

TLC§ 409.005 and Rules 120.3 and 129.4 provide the requirements regarding use of this report. The complete rule text is available on the DWC website at: www.tdi.state.tx.us



DWC FORM-6 (Rev. 10/05) Page 2

DIVISION OF WORKERS' COMPENSATION

7/21/2009 7:28

Employee Timecard Report

^ Adjusted Value

{ Previous Day Punch

< Previous Pay Period Punch

CES Environmental Services, Inc 7/12/2009 - 7/18/2009

? Exception

+ Added Item

* Tardy

HTO - Hours Toward Weekly Overtime

~ Holiday Punch Badge: 123 ID:0006

| Encinia, | Jose | (Tankwash) |
|----------|------|------------|
| | | |

| Date | in | Out | in | Out | Total | Overtime | нто Ар | proved By | Notes |
|--------------------|--------|---------------|------------|-------|-------|------------|--------------|--------------|-------|
| 7/12/2009 Sun | None | | | | 0:00 | 0:00 | 0:00 | 0:00 | |
| 7/13/2009 Mon | 13:37 | 19:36 | 20:00 | 23:00 | 8:59 | 0:00 | 8:59 | 0:00 | |
| 7/14/2009 Tue | 13:30 | 19:19 | 19:45 | 22:55 | 8:59 | 0:00 | 17:58 | 0:00 | |
| 7/15/2009 Wed | 13:40 | 21:23 | 22:00 | 23:02 | 8:45 | 0:00 | 26:43 | 0:00 | |
| 7/16/2009 Thu | 7:00 | 8:33 | 13:34 | 23:01 | 11:00 | 0:00 | 37:43 | 0:00 | |
| 7/17/2009 Fri | 13:57 | ? | | | ? | ? | ?37:43 | 0:00 | |
| 7/18/2009 Sat | None | | | | 0:00 | 0:00 | ?37:43 | 0:00 | |
| <u>Department</u> | Reg | <u>0T</u> | <u>Vac</u> | Sick | Hol | <u>Per</u> | <u>Other</u> | <u>Total</u> | |
| Tankwash | ?37:43 | ?0:00 | ?0:00 | ?0:00 | ?0:00 | ?0:00 | ?0:00 | ?37:43 | |
| Totals | 237:43 | <i>20:</i> 50 | ?0:00 | 70:00 | 70:00 | ?0:00 | ?0:00 | ?37.43 | |
| | 40 | 646 | | | | | | 4646 | |
| $(u_{-1}(t_{-1}))$ | | | | | | | | 100 | |

Employee Signature

Date

Approved By

Notes:

<u>Date</u>

Editor

<u>Text</u>

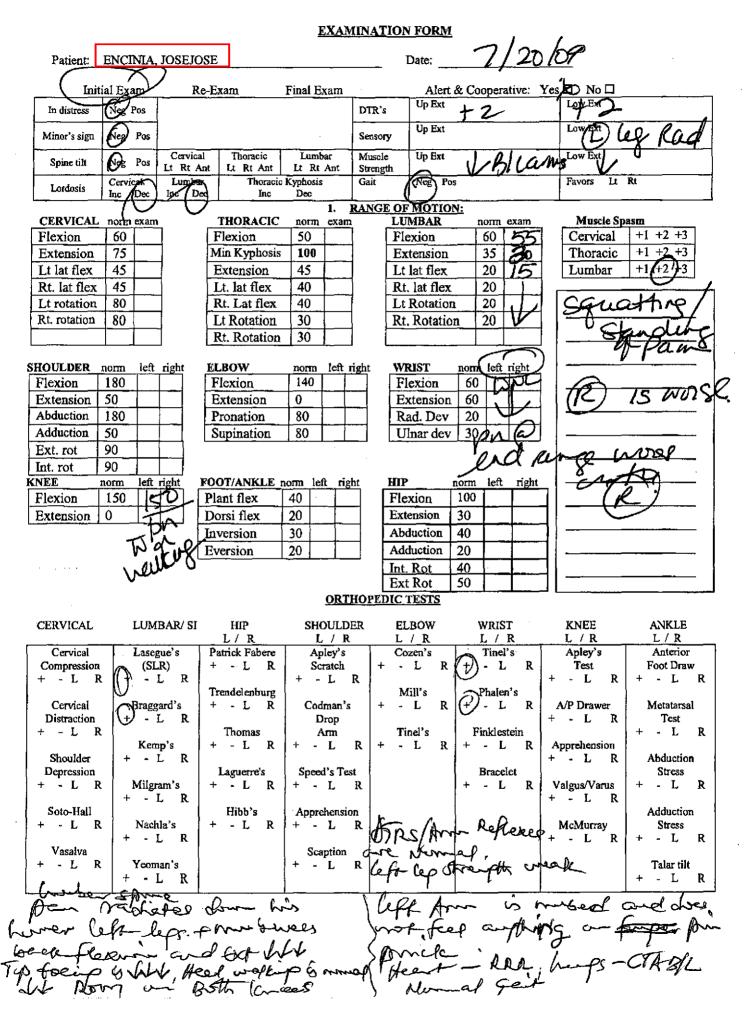
None Listed

Fri.

Allied Medical Center

Initial WC Evaluation Office: East

| PATIENT NAME: ENCINIA, JOSE DATE: 7/20/09 |
|--|
| SOC. SEC. #: (b) (4) AGE: |
| Insurance Carrier: Network: |
| |
| PRESENT MEDICAL CONDITION: VITAL STATISTICS |
| WT: 159 HT: 5"5" BP: 118 182 PULSE: 57 RESP: TEMP: |
| WT: 159 HT: 5"5" BP: 118 182 PULSE: 57 RESP: TEMP: DOI: 17/109 OCCUPATION: Tank Washer injury reported to: Supervisor AREAS OF COMPENSABILITY: 1. Blc Oness 2. Blc Wasts 3/ Helands 4. Clembar |
| AREAS OF COMPENSABILITY: 1. Blc brees 2. Blc Wests 3/ Alhours 4. Clembar |
| CHIEF COMPLAINT: Percus Pain Description: Aching burning sharp radiating numbress tingling |
| AGGRAVATED BY: SITTING STANDING WALKING STAIRS COUGHING BENDING |
| ALLEVIATED BY: |
| Pt was involved in a chemical explosion while a world. He was coming about the ladder, on a tank. Next to a tank that exploded. — he ended up talling on Blickells and Blickells and Blickells and builts of a fail and feet funning he tripped but hid hot fail and got his balance and lept running. The lower and and or running. The lower and and or running. |
| MEDICATIONS: NA CYLLAND MOMO ALLERGIES: MCFDA- PAST ILLNESSES: HOSPITALIZATION/SURGERIES: PRIOR WORK INJURIES/MVA: |
| SOCIAL/FAMILY HISTORY |
| MARITAL STATUS: S (M)D W #OF CHILDREN: 9 LIVING STATUS: (188. |
| SMOKER: YES NO ALCOHOL: YES NO SOCIAL HEAVY DRUGUSE: YES NO |



| PAT | FIENT: ENCINIA JOSE SOCI | IAL SEC | URITY: (b) (4) |
|----------------|--|----------------|---|
| <u> </u> | | | |
| Cervical | | 719.54 | Stiffness of joint, hand |
| | | 726.10 | Disorders of bursae and tendons in shoulder region |
| 333.83 | Spasmodic torticollis | 726.11 | Calcifying tendinitis of shoulder |
| 721.0 | Cervical Spondylosis without myelopathy | 726.31 | Medial epicondylitis |
| 721.1 | Cervical Spondylosis with myelopathy | 726.32 | Lateral epicondylitis |
| 722.0 . | Displacement of the Cervical intervertebral disc wihout myelopathy | 727.05 | Tenosynovitis hand and wrist, other |
| 722.71 | Intervertebral disc disorder with myelopathy- Cervical | 726,0 | Adhesive capsulitis of shoulder |
| 722.81 | Postlaminectomy syndrome - cervical | 726.10 | Rotator cuff syndrome |
| 723.1 | Cervicalgia | 842.02 | Sprain/strain of radiocarpal (joint) (Ligament) |
| 723.5 | Torticollis, unspecified | 842.10 | Sprain/Strain of hand, unspecified |
| 784.0 | Headache | 840.0 | Sprain/strain of acromioclavicular (joint) (Ligament) |
| 847.0 | Sprain/strain of neck | 840.1 | Sprain/strain of coracoclvicular (ligament) |
| Thoracic | | Lower Ex | xtremities |
| 721.2 | Thoracic spondylosis without Myelopathy | 717.7 | Chondromalacaia of patellae |
| 721.41 | Thoracic spondylosis with Myelopathy | 719.57 | Stiffness of joint, ankle and foot |
| 722.11 | Thoracic intervertebral disc without myelopathy | 726,5 | Enthesopathy of hip region |
| 722.31 | Schmorl's nodes- Thoracic | 728.71 | Plantar fascitis |
| 722.51 | Degeneration of thoracic or thoracolumbar intervertebral disc | 729.5 | Pain in limb |
| 722.72 | Intervertebral disc disorder with Myelopathy_ Thoracic | 736.81 | Unequal leg length (acquired) |
| 722.82 | Postlaminectomy syndrome- Thoracic | 843.8 | Sprain/strain of hip and thigh, other |
| 724.1 | | 843.8 844.0 | Sprain/strain of interal collateral ligament of knee |
| | Pain in thoracic spine | | |
| 724.4 | Thoracic or lumbosacral neuritis or radiculitis, unspecified | 844.1 | Sprain/strain of medical collateral ligament of knee |
| 737.34 | Thoracogenic scoliosis | 844.2 | Sprain/strain of cruciate legament of knee |
| 739.2 | Nonallopathic leasions- Thoracic Region | 845.00 | Sprain/strain of ankle, unspecified |
| 847.1 | Sprain/strain of Thoracic region | 845.10 | prain/strain of foot, unspecified |
| Lumbar/Sa | Lumbar/Sacrum/Pelvis | | NMS |
| 719.55 | Stiffness of Joint, pelvic region and thigh | 728.85 | Spasm of muscle |
| 721.3 | Lumbosacral spondylosis without myelopathy | 729.1 | Myalgia and myositis, unspecified |
| 721.42 | Lumbar spondylosis with myelopathy | 737.29 | Lordosis, other |
| 722.10 | Lumbar Intervertebral disc without myelopathy | 737.43 | Scoliosis |
| 722.32 | Schmori's nodes- Lumbar | 738.4 | Acquired spondylolisthesis |
| 722.52 | Degeneration of lumbar or lumbosacral intervertebral disc | 756.12 | Spondylolisthesis |
| 722,73 | Intervertebral disc disorder with myelopathy- lumbar | 756.14 | Hemivertebra |
| 722.83 | Postlaminectomy syndrome- Lumbar | 781.92 | Abnormal posture |
| 724.02 | Spinal Stenosis- Lumbar | 101.72 | Adiothiai postate |
| 724.02 | | Namedagi | • |
| | Lumbago | Neurologi | ic . |
| 724.3 | Sciatica | 327.01 | D. O |
| 724.4 | Thoracic or Lumbosacral neuritis or radiculitis, unspecified | 337.21 | Reflex sympathetic dystrophy, of the upper limb |
| 724.6 | Disorders of sacrum | 337.22 | Reflex sympathetic dystrophy, of the lower limb |
| 724.8 | Other back symptoms | 350.1 | Trigeminal neuralgia |
| 724.9 | Other back disorders | 723.4 | Branchial neuritis or radiculitis, unspecified |
| 724.79 | Disorders of coccyx, other | 729.2 | Neuralgia, neuritis and radiculitis, unspecified |
| 739.3 | Nonallopathic lesions-lumbar region | 953.1 | Dorsal root injury |
| 739.4 | Nonallopathic lesions- savral region | 953.4 | Brachial plexus injury |
| 739.5 | Nonallopathic leasion- pelvic region | | |
| 846.0 | Sprain/strain of lumbosavcral (Joint) (Ligament) | Other | |
| 846.1 | Sprain/strain of sacroiliac (ligament) | 388.30 | Tinnitus, unspecified |
| 847.2 | Sprain/strain of lumbar region | 780.4 | Dizziness and giddiness; vertigo |
| 847.3 | Sprain/strain of sacrum | 715.09 | Osteoarthrosis, generalized, multiple sites |
| 847.4 | Sprain/strain of coccyx | 720.0 | Ankylosing spondylitis |
| 953.2 | Lumbar root injury | 786.50 | Chest pain, unspecified |
| 953.3 | | | |
| 953.5 953.5 | Lumbosacral plexus injury | | 1 1 011 |
| Upper Exti | remities | BI | c hand lunst spirt instal spirt tall spirt |
| 719.51 | Stiffness of joint, shoulder region | 1. | 1 1 - 1 - 1 - 1 st |
| 719.52 | Stiffness fo jont, upper arm | | MOW OF |
| 719.53 | Stiffness of joint, forearm | 7 | |
| | | Bli | Lace SPIST |
| Others: | | <u> </u> | [|

| Patie | ent: ENCINIA, JOSE |
|------------|---|
| TREA | TMENT PLAN: XR-\(\text{C/spine: APOM/AP5/Lat/Flx/Ext.} \) \(\text{T/spine. AP/Lat.} \) \(\text{L/spine. AP/Lat/Flx/Ext.} \) \(\text{XR Digitization} \) \(\text{MRI:} \) \(\text{C/spine } \text{T/spine } \text{D/spine} \) \(\text{Shoulder} \) \(\text{Knee } \text{Wrist/hand } \) \(\text{L/spine } \text{T/spine } \) \(\text{D/spine } \) \(\text{Shoulder} \) \(\text{Knee } \text{ Wrist/hand } \) \(\text{L/spine } \) \(|
| <u>.</u> | CT scan: Head C/spine T/spine L/spine |
| | Pain Management Specialist: |
| P | Behavioral Medicine Council: WMHE) Metal Health Evaluation (IT) Individual Therapy |
| | EMG of the: Upper extremities. Upper extremities. |
| <u> </u> | Orthopedic evaluation of the: C/spine T/spine L/spine _ Shoulder _ Knee Wrist/hand _ Foot/ Ankle |
| | Impairment Rating: STAT/CLINICAL OTHER: |
| • | FCE referral:BASE LINEWH or CPMP PROGRAMRTN TO WORK |
| | Other: |
| | Return to Work Programs: Work Hardening 2 weeks 4weeks 6weeks Work Conditioning 2 weeks 4weeks 6weeks Chronic Pain Management Program 2 weeks 4weeks 6weeks |
| . | Aquatic Therapy Department: □ Requested CPT Code for approval: 97113 □ TX Frequency:Times per week for# weeks |
| 90 | PHYSICAL MEDICINE AND REHABILITATION |
| (- | ORequested CPT Code for approval: 97110 97116 97112 9719 97104 TX Frequency: Times per week for #weeks |
| | Li Additional Rody parts: Refer to: 131 Pil |
| | TX Frequency:Times per week for# weeks |
| MEDIO | CAL NECESSITY: The purpose for the above treatment is to: |
| <i>y</i> – | ease ROM Pricrease Strength Pricrease Tolerance Decrease Swelling ease Pain Other: |
| Notes:_ | |
| | |
| Doctor' | s Signature: Date: 2/20/59 |



Claim and Insurance Services P.O. Box 12029 Austin, Texas 78711-2029

NOTIFICATION OF MAXIMUM MEDICAL IMPROVEMENT/FIRST IMPAIRMENT INCOME

DATE;

07/13/2009

TO:

HERNANDEZ, JOSEPH 3131 SCOTCH MOSS LN LA PORTE TX 77571-3645

RE:

Date of Injury: Nature of Injury: Part of Body Injured: Employee ŠSN:

DWC #:

Carrier Name: Carrier Claim Number:

Employer:

06/26/2009

HEAT PROSTRATION

BODY SYSTEMS AND MULTIPLE BODY SYSTEMS

85-33-0708

Texas Mutual Insurance Company

C E S ENVIRONMENTAL SERVICES I

4904 GRIGGS RD

HOUSTON TX 77021-3208

You have been certified to have reached Maximum Medical Improvement (MMI) and had an Impairment Rating (IR) assigned. Entitlement to Impairment Income Benefits (IIBs) begins the day after the date you were certified as having reached MMI. For each percentage point of the impairment rating, you will receive 3 weeks of benefits. The amount of your IIBs benefit is based on 70% of the reported Average Weekly Wage of \$0.00.

We have received a report from Dr.DOLAN, JEAN THERESA(copy attached) certifying that you have reached MMI and you do not have any permanent impairment as a result of this compensable injury. Based on this report you are not eligible for any income benefits of any type. You remain entitled to necessary medical benefits related to this injury.

If you are expected to be paid benefits for a period of eight weeks or more, you may request that we make benefit payments by electronic funds transfer directly to your bank account. Also, you may request that we change your IIBs to a monthly payment.

Explanatory Comments:

If you do not agree with this certification of MMI and/or IR you have 90 days from the date you receive this notification of MMI and/or IR to file a dispute with the Texas Department of Insurance, Division of Workers' Compensation by contacting the Division office handling your claim at 1-800-252-7031.

If you are interested in having your payments made directly to your bank account or do not agree with the finding of MMI, IR certified by the doctor or the amount being paid please contact me:

Adjuster's Name: Toll Free Telephone #; Fax #/E-mail Address:

EVELYN J. SASSER (800) 859-5995 (512) 224-3889

If we are unable to resolve the issue to your satisfaction, you may contact the Texas Department of Insurance, Division of Workers' Compensation for further assistance. You have the right to request a Benefit Review Conference. You can contact the Division office handling your claim at 1-800-252-7031.

If you would like to receive notices such as this by facsimile or e-mail, please contact me and provide your facsimile number or e-mail address

Please note that making a false or fraudulent workers' compensation claim is a crime that may result in fines and/or imprisonment.

CC HERNANDEZ, JOSEPH C E S ENVIRONMENTAL SERVICES I



07/06/09 09:54

To: Prabhakar Thangudu 7136761676

Pg 002

NARRATIVE HISTORY

Patient:

Hernandez, Joseph

DX:

Heat Exhaustion, Unspecified

Physician:

Jean T Dolan, MD

Location:

CMC - Houston i-10 East

The patient's injury occured on 06/26/2009. The patient stated, "I was over heated and my head and stomach started hurting."

The patient was evaluated on 07/01/2009

Date of MMI 07/01/2009

The treatment plan included Regular Activity.

Findings of the certifying examination/explanation of performed analysis:992.5 Heat Exhaustion, Unspecified

Lab and X-Ray Tests: N/A

Description of the results of the most recent clinical evaluation of the employee

Current Clinical Status: Released from care., Activity Status is Regular Activity. Treatment Status is Released from care.

Diagnosis and clinical findings of permanent impairment: The employee does not have any permanent impairment as a result of the compensable injury.

AMA Guides to the Evaluation of Permanent Impairment Edition

None

Employee - You are required to report your injury to your employer within 30 days if your employer has workers compensation insurance. You have the right to tree assistance from the Texas Department of insurance, Division of workers' Compensation and may be entitled to certain medical and income benefits. For further information call your local Division field office or 1(500)-252-7031.

Empleado - Es necesario que repone su lesión a su empleador demro de 30 días a panir de la fecha en que as leaionó al as que au empleador cuanta con un asguro de combenación para trabajadores. Usted tiene derecho a recibir asistencia gratuita por parte de la División de Compensación para Trabajadores, y también puede tener derecho a cienos beneficios médicos y monetarios. Para mayor información comuniquese con la oficina local de la División al teefono 1-600-262-7031.

| REPORT OF MEDICAL EVALUATION | | | | | CLAIM #: | CLAIM #: | | | | | |
|---|---|---|--|--|--|--|---|---|--------------------------|--|--|
| PART I: GENERAL INFORMATION | | | | 4 Injured Employee's Name (Leet, First, Mi) Mernandez, Joseph | | | | Centifying Doctor's Name and Licensure Jean T Colon, MD | | | |
| Workers' Compensation Insurance Carrier Texas Mutual Insurance Company | | | 6. Date of injury 06/26/2009 | 6. Social Security Number | | | 10. Certifying Doctor's License Number and Jurisdiction MDJ7279TX TX | | | | |
| 2. Employers Name CES Environmental | | | 7. Employee's Phone # | | | | 11. Čertifylng Do (Ph) (ego)733-70 | 11. Certifying Doctor's Phone and Fax #'s | | | |
| 3. Employer's Address 4804 Grigge Rd | | | e. Employes à Addrésa | | | | 12. Certifying Doctor's Address PO Box 9005, 15910 Mildway Rd | | | | |
| Olty Houston | State TX | Zip 770212208 | chy (b) (4) | Stat | e Zip | 1 | City ADDISON | State TX | Zρ | | |
| | i i ii | | | | | _ | ASSION! | 1^ | 75001-9005 | | |
| PART II: DOCT: | | | | this evalu | ation. Only a do | ctor serving in on | e of the followin | s rolen in | <u> </u> | | |
| authorized to eval | luete MMI/imp | sirment and file t | his report (Works | re' Compe | nestion Rule 1: | 30.1 governe euch | authorization): | _ | | | |
| X Treating Doctor | _ | · | ing Doctor acting in | , | _ | _ | signated Doctor S | • | Division | | |
| | | • • • | | | • | sairment after a Dei rt or the MMI/impal | • | | | | |
| | | | | | | urate and complies eation claim is a cri | | | | | |
| imprisonment. | | of Certifying Docto | | | are especial | ~~ MUS | Date of Cert | | /01/2009 | | |
| PARTIII: MEDIC | | | | | | | 3000 | | | | |
| 15. Date of Exam | | Diagnosis 1) 9 Codes) 992 | | 2) | | 3) | | 4) | | | |
| 07/01/2009 | | | | | | following definitio | | | | | |
| a) X Yee, I certify that not reach NOTE - The fact the PART IV: PERM. The title employer impairment means to be permanent. It impairment resulting | that the employand the employed MMI is docated an employed ANENT IMP. The tree tree the end of the finding that given a comp | yee reached antation relating to see has NOT reach sumented in the acreaches either Claim and the see reaches either Claim and the see or functional about impairment exists ensable injury, base | this certification in ed MMI but is experite the control of the co | CLINIC The attach sclad to res story MMI c yee has pe sting after sed upon c n objective | AL (mark one) ed narrative. ach MMI on or al lose not signify to armanent impai MMI that results blactive clinical medical eviden- | MMI on 07/01/2 | no longer entitled of the companies to injury and is rea processing a median | ble injury. ssonably presur lical finding of | oloyee nefits. med | | |
| a designated docto a) XI certify that | | • | • • • | • | | romable injury | OR | | | | |
| b) I certify that which was determine provides document Parmanent Impairm | the employee ned in accorda ation involved nant published | has permanent Impose with the requirement in the calculation of the the Americant I | palment as a resul ements of the Text of the impairment re Medical Association | it of the conse Workers ating sasign | mpensable injury Compensation and using the fol third edition, s | The amount of processing and Commission of the country of the countr | ermanent Impairm on Rules. The en o Guides to the E ruery 1989. | teched nerrati | _%, we | | |
| PART V: TREAT | NG DOCTO | R'S AGREEMEI | NT OR DISAGRE | EMENT | WITH ANOTH | ER DOCTOR'S | CERTIFICATIO | N | | | |
| 19. Treating Doctor | 's Name and [| Degree | 22. 🔲 1 | GREE / | I DISAGRE | E with the certifying | doctor's certificat | ion of MMI. | | | |
| 20. Treating Doctor | 'a License Nur | nber and Jurisdicti | on 29. | AGREE / | □ DISAGRE | E with the certifying | doctor's finding o | of no impairmen | ı. OR | | |
| 21. Treating Doctor | | x #8 | ╗ | AGREE / | | E with the Impairme | | | | | |
| (Ph) 24 Lunderstand II | (Fex) | intervenentation s | ibout a worker's co | mpeneatio | n claim is a crim | a that can result in t | inea and/or impris | onment | | | |
| 24. I understand that making a misrepresentation about a worker's compensation claim is a crime that can result in fines and/or imprisonment. Signature of Treating Doctor | | | | | | | | | | | |
| ormation, call our ITA: Usted tiene d ra mayer informat | ceptions, you Open Record erechte per le tion liame a la | are entitled by la s section at 612-6 y de eaber, revies sección de archi | w to know,review 304-4437 Ir y corregir intorn | nación qu | a la División ha | that DWC Collect | | - | сіолев. | | |
| /C FUR M-69 (| C FORM-89 (Rev. 10/05) Page 1 | | | | | | DIVISION OF WORKERS' COMPENSATION | | | | |



Employer's Authorization for Examination or Treatment

| Centers (MUST PRESENT PHO | TO (D AT TIME OF SERVICE) |
|--|--|
| Patient Name: Joseph Hernandez | SSN: (b) (4) |
| Company Name: | Date of Birth: (b) (4) |
| Location #/Street Address: CES Environmental S | |
| Temporary Staffing Agency: 4904 Griggs R Houston, TX 770 | 0. 021 |
| WORK-RELATED INJURY 3) 6/01146 | ESS DOT PHYSICAL |
| Post-Accident Substance Abuse Testing: | Preplacement |
| Drug Screen | Recertification |
| Breath Alcohol | Exit |
| Drug Screen and Breath Alcohol | Audiogram |
| Urine Collection Only | Regulated Drug Screen |
| * | Urine Collection Only |
| DOT Regulated | Breath Alcohol |
| Non-regulated | |
| PRE-PLACEMENT EVALUATION | SUBSTANCE ABUSE TESTING |
| Job Title: | Regulated |
| Physical Exam | Non-regulated |
| HPE | Urine Collection Only |
| Regulated Drug Screen | Rapid Test |
| Non-regulated Drug Screen | Pre-placement |
| Urine Collection Only | Reasonable Suspicion |
| Hair Collection | Random |
| Audiogram | Periodic Periodic |
| | Post-accident |
| | ✓ Follow-up |
| SPECIAL PHYSICAL EXAMINATIONS | Breath Alcohol |
| Asbestos | |
| Respirator | BILLING |
| Hazmat | Employee to pay charges at time of service |
| Baseline | Workers' Compensation |
| Other | Insurance Co: |
| | Policy #: |
| _ | Phone #; |
| Authorized By: Rahmellingh | Title: HSE Manager |
| Phone: 713-676-1460 | Date: 7-1-09 |
| (copies of this form available | le at www.concentrahealth.com) |

Claim Number:

Concentra Medical Centers

10909 East Frwy Houston, TX 77029 Phone: (713) 973-7943 Fax: (713) 973-7947

Service Date: 07/01/2009 Case Date: 06/26/2009

Physician Activity Status Report

Patient: Hernandez, Joseph SSN: _{XXX-XX}(b) (4) Address: Home: Work: Ext.:

Employer Location: CES Environmental

4904 Griggs Rd

Contact: Prabhakar Thangudu

Address: Houston, TX 770213208 Role: DER/Primary

Auth. by:

Phone: (281) 433-9792 Ext.: Fax: (713) 676-1676

This Visit: Time In: 02:28 pm Time Out: 03:23 pm Recordable: N/A

Visit Type: New

Treating Provider: Jean T. Dolan, MD

Medications:

Diagnosis: 992.5 Heat Exhaustion, Unspecified

☐ Dispensed Prescription Medication to Patient ☐ Dispensed Over-The-Counter Prescription

☐ Written Prescription given to Patient

Patient Status:

Regular Activity - Released from care

Return to regular duty on 07/01/2009

Remarks:

Employer Notice:

The prescribed activity recommendations are suggested guidelines to assist in the patient's treatment and rehabilitation. Your employee has been informed that the activity prescription is expected to be followed at work and away from work,

Anticipated Date of Maximum Medical Improvement:

Actual Date of Maximum Medical Improvement: 07/01/2009

Next Visit(s):

Patient Notice: It is essential to your recovery that you keep your scheduled appointments, but should you need to reschedule or cancel your appointment, please contact the clinic. Thank you for your cooperation.

Concentra

Date of Service: 07/01/2009 Date of Injury: 06/26/2009

Attn: Prabhakar Thangudu CES Environmental 4904 Griggs Rd Houston, TX 770213208

Dear Prabhakar Thangudu:

Your employee Joseph Hernandez received treatment for a new work related injury at our CMC - Houston I-10 East clinic on 07/01/2009.

The billings for this injury care will be sent to Texas Mutual Insurance Company. Please help us provide the best care to your injured employee by filing the Employer's First Report of Injury with your carrier, if not already filed. This will ensure timely reporting and management of this workers' compensation claim.

If you have any questions or the above information is incorrect, please call our office or fax any changes to the attention of the Billing Department.

Sincerely,

CMC - Houston I-10 East Central Business Office 800-733-7098 972-458-7678 Employee - You are required to report your injury to your employer within 30 days if your employer has workers' compensation insurance. You have the right to free assistance from the Texas Workers' Compensation Commission and may be entitled to certain medical; and income benefits. For further information call your local Commission field office or 1(800)-252-7031.



Trabajador - Es necesario que usted reporte su lesión a su empleador dentro de 30 dias a partir del dia en que se lesionó, si su empleador tiene seguro de compensación para trabajadores. la Comisión Tejana de Compensación para Trabajadores le ofrece asistencia gratuita, también puede que usted tenge derecho a ciertos beneficios médicos y monelarios. Para mayor información llame a la oficina local de la Comisión 1-800-252-7031.

| TEXAS WORK | ERS' COMPENSATION WORK STAT | US REPORT | |
|--|---|---|------------------------------------|
| PART I: GENERAL INFORMATION | 5. Doctor's Name and Degree Jean T. Dolan, MD | (for transmission purposes only) | Date Being Sent 07/01/2009 |
| Injured Employee's Name | 6. Clinic/Facility Name | 9. Employer's Name | |
| loseph Hernandez | CMC - Houston I-10 East | CES Environmental | |
| 2. Date of Injury 3. Social Security Number (b) (4) | 7. Clinic/Facility/Doctor Phone & Fax (713)973-7943 (713)973-7947 | 10. Employer's Fax # or Email A (713)676-1676 | Address (if known) |
| • • • | 8. Clinic/Facility/Doctor Address (street address) | 11. Insurance Carrier | |
| Patient states :"I was over heated and my head and stomach stared hurting." | 10909 East Frwy | Texas Mutual Insurance Co | - · · · |
| | City State Zip Houston TX 77029 | 12. Carrier's Fax # or Email Add (512)224-3889 | dress (if known) |
| | (FULLY COMPLETE ONE INCLUDING ESTIMATED DATES A | AND DESCRIPTION IN 13(c) | AS APPLICABLE) |
| (b) will allow the employee to return to we expected to last through (c) has prevented and still prevents the en | ork as of 07/01/2009 (date) without restrictions. ork as of (date) with the restrictions in (date). | _(date) and is expected to | continue |
| PART III: ACTIVITY RESTRICTIONS* (I | REQUIRED IS BOX 13/b) IS CHECKED) | | |
| 2-7 | | <u> </u> | |
| 14. POSTURE RESTRICTIONS (if any): | 17. MOTION RESTRICTIONS (if any): | 19. MISC. RESTRIC | CTIONS (if any): |
| Max Hours per day: 0 2 4 6 8 Other | Max Hours per day: 0 2 4 6 8 Other | Max hours per | day of work: |
| Standing | Walking \ | Sit/Stretch bres | iks ofper |
| Sitting | Climbing stairs/ladders | | |
| | | Must wear splin | |
| Kneeling/Squatting | _ Grasping/Squeezing | Must use crutch | nes at all times |
| Bending/Stooping | Wrist flexion/extension | No driving/oper | ating heavy equipment |
| Pushing/Pulling | Reaching | Can only drive | automatic transmission |
| Twisting Twisting | Overhead Reaching | □ No work/ □ | hours/day work: |
| | | | |
| Other: | Keyboarding | in extreme | hot/cold environments |
| 15. RESTRICTIONS SPECIFIC TO (if applica | nble): Other: | at heights o | or on scaffolding |
| L Hand/Wrist R Hand/Wrist | 18. LIFT/CARRY RESTRICTIONS (if any): | Must keep | |
| | eck May not lift/carry objects more thanlbs | - | Clean & Dry |
| | | 1 | - ' |
| | | No skin contact | t with: |
| L Foot/Ankle R Foot/Ankle | May not perform any lifting/carrying | Dressing chang | es necessary at work |
| Other: | Other: | No running | |
| 16. OTHER RESTRICTIONS (if any): | | 20. MEDICATION F | RESTRICTIONS(if any): |
| | | Must take presc | ription medication(s) |
| | | | over-the-counter meds |
| *These restrictions are based on the doctor's best unde | rstanding of the employee's essential job functions. If a particular | Medication may | make drowsy (possible |
| | odified duty that meets these restrictions is not available, the patie | | - " |
| should be considered to be off work. Note - these restric | ctions should be followed outside of work as well as at work. | salety/unving iss | sues) |
| PART IV: TREATMENT/FOLLOW-UP AF | POINTMENT INFORMATION | | |
| | Expected Follow-up Services Include: | <u>, , , , , , , , , , , , , , , , , , , </u> | |
| | Evaluation by the treating doctor on | (date) | at am/pm |
| | Referral to/Consult withon_ | | atam/pm |
| | Physical medicineX per week forweeks starting | | |
| | | on (date) | |
| | None. This is the last scheduled visit for this problem. A | | dical care is anticipated |
| Date / Time of Visit EMPLOYEE'S SIGNATURE | | e of Doctor: | Treating doctor |
| 07/01/2009 02:28 pm Discharge Time | | Designated doctor Carrier-selected RME | Referral doctor |
| 07/01/2009 03:23 pm | I I I I I I I I I I I I I I I I I I I | DWC-selected RME | ☐ Consulting doctor ☐ Other doctor |
| <u> </u> | | · · · · · · · · · · · · · · · · · · · | |

DWC FORM-73 (Rev. 10/05) Page 1



DIVISION OF WORKERS' COMPENSATION

Employee - You are required to report your injury to your employer within 30 days if your employer has workers' compensation insurance. You have the right to free assistance from the Texas Workers' Compensation Commission and may be entitled to certain medical and income benefits. For further information call your local Commission field office or 1(800)-252-7031.



Trabajador - Es necesario que usted reporte su lesión a su empleador dentro de 30 dias a partir del día en que se lesionó, si su empleador tiene seguro de compensación para trabajadores. la Comisión Tejana de Compensación para Trabajadores le ofrece asistencia gratuita, tembién puede que usted tenga derecho a ciertos beneficios médicos y monetarios. Para mayor información llame a la oficina local de la Comisión 1-800-252-7031.

| TEXAS WORKE | RS' COMPENSATION WOR | RK STATUS REPORT | |
|---|---|---|---------------------------------------|
| PARTY (SENERAL INSTITUTION | Doctor's Name and Degree | (for transmission purposes only) | Date Being Sent |
| | ean T. Dolan, MD | | 07/01/2009 |
| | Clinic/Facility Name | Employer's Name CES Environmental | |
| | MC - Houston I-10 East Clinic/Facility/Doctor Phone & Fax | 10. Employer's Fax # or Ema | il Address (if known) |
| | 713)973-7943 (713)973-7947 | (713)676-1676 | o y tool ood (ii kilomiy |
| | Clinic/Facility/Doctor Address (street address) | 11. Insurance Carrier | |
| | 0909 East Frwy | Texas Mutual Insurance (| Company |
| stomach stared hurting." | y State Zip | 12. Carrier's Fax # or Email / | |
| · H | ouston TX 77029 | (512)224-3889 | |
| PART II: WORK STATUS INFORMATION | (FULLY COMPLETE ONE INCLUDING ESTIMA | ATED DATES AND DESCRIPTION IN 13 | (c) AS APPLICABLE) |
| 13. The injured employee's medical condition re- | | | |
| | k as of 07/01/2009 (date) without rest | | |
| | k as of(date) with the res | · ···· · · · · | which are |
| expected to last through | | - | |
| _ | loyee from returning to work as of | (date) and is expected | to continue |
| | ng describes how this injury prevents the | ne employee from returning to wo | rk; |
| | | | |
| PART III: ACTIVITY RESTRICTIONS* (RI | QUIRED IF BOX 13(b) IS CHECKED | D) | |
| 14. POSTURE RESTRICTIONS (if any): | 17. MOTION RESTRICTIONS (if any | v): 19. MISC. REST | RICTIONS (if any): |
| Max Hours per day: 0 2 4 6 8 Other | | " | er day of work: |
| Standing | Walking DDDD | _ _ | • |
| Standing | | Sit/Stretch br | eaks ofper |
| Sitting | Climbing stairs/ladders | Must wear sp | lint/cast at work |
| Kneeling/Squatting | Grasping/Squeezing | ☐ Must use crui | ches at all times |
| Bending/Stooping | Wrist flexion/extension | ╗─────│ | erating heavy equipment |
| | | _ = | • |
| Pushing/Pulling | Reaching | Can only driv | e automatic transmission |
| Twisting | Overhead Reaching UUU[| No work/ [| hours/day work: |
| Other: | ☐ ☐ in extrem | e hot/cold environments | |
| | Keyboarding | ¬ = 1 = = | |
| 15. RESTRICTIONS SPECIFIC TO (if applicab | | | or on scaffolding |
| L Hand/Wrist R Hand/Wrist | 18. LIFT/CARRY RESTRICTIONS (I | fany): | |
| L Arm R Arm Nec | May not lift/carry objects more that | anibs 🗍 Elevated | Clean & Dry |
| L Leg R Leg Bac | for more thanhours per da | | ct with: |
| | i — | | |
| L Foot/Ankle R Foot/Ankle | May not perform any lifting/carrying | ^{rig} ☐ Dressing chai | nges necessary at work |
| Other: | _ | No running | |
| 16. OTHER RESTRICTIONS (if any): | | 20 MEDICATION | RESTRICTIONS(if any): |
| (i. u. i. j), | | — | |
| | | | scription medication(s) |
| | | Advised to tak | e over-the-counter meds |
| These restrictions are based on the doctor's best unders | | | y make drowsy (possible |
| estriction does not apply, it should be disregarded. If mod | • | l eatety/driving | ssues) |
| hould be considered to be off work. Note - these restricti | ons should be followed outside of work as well as | at work. | |
| PART IV: TREATMENT/FOLLOW-UP APP | OINTMENT INFORMATION | | |
| 1. Work Injury Diagnosis Information: 22. | xpected Follow-up Services Include: | | |
| 497.5 Heat Exhaustion Unspectied I— | aluation by the treating doctor on | | e) at am/pm |
| ☐ Referral to/Consult withon(date) ata | | | , .] |
| Physical medicine X per week for weeks starting on | | | e) at am/pm |
| Special studies (list):onon(date) atam/p | | | |
| | one. This is the last scheduled visit for this | | |
| Date / Time of Visit EMPLOYEE'S SIGNATURE | DOCTOR'S SIGNATURE Visit T | □ Declarated deptor | Treating doctor |
| 7/01/2009 02:28 pm Discharge Time | ⊠ Ir | nitial Designated doctor Carrier-selected RME | ☐ Referral doctor ☐ Consulting doctor |
| 7/01/2009 03:23 pm | | ollow-up DWC-selected RME | Other doctor |

DWC FORM-73 (Rev. 10/05) Page 1



DIVISION OF WORKERS' COMPENSATION

| Alcohol Testing Form (Non-DOT) | | • |
|--|--|-------------------------------------|
| (The instructions for completing this form are on the back of Copy 3) | | Scr |
| STEP 1: TO BE COMPLETED BY ALCOHOL TECHNICIAN | 1 | een (|
| A: Employee Name TOSEPH HERNANDEN | | Affix Or Print Screening Results |
| B: SSN or Employee ID No. | | suits] |
| C: Employer Name <u>CES</u> . Ensurjon mental | | Here |
| Street 4904 Driggs | | |
| Hon, a. 71021 | | ▼ Affix |
| City, ST ZIP | | |
| DER Name and Telephone No. Problem 1 Transport 1 1 1 3 9 7 9 DER Name DER (Area Code & Phone Number) | | With Ta |
| D: Reason for Test: Random Reasonable Susp. Prost-Accident Return to Duty Follow-up Pre-employment | | mper |
| STEP 2: TO BE COMPLETED BY EMPLOYEE | | Evi |
| I certify that I am about to submit to alcohol testing and that the identifying information provided on the form is true and correcte | | Tamper Evident Tape |
| 7-1-09 | SECONOMITER CC 001182 | ਲੋ |
| Sgnature of Employe Date Month / Day / Year | 160 80. 72 | • |
| STEP 3: TO BE COMPLETED BY ALCOHOL TECHNICIAN | ر تر مدونت راب وما مها مصور الرابعي | Affix Or Confirmi |
| (If the technician conducting the screening test is not the same technician who will be conducting the | [SEC: 585330708, | ugu X |
| confirmation test, each technician must complete their own form.) I certify that I have conducted alcohol testing on the above named individual, that I am qualified to operate the testing device(s) identified, and that the results | SCREENING TEST | Affix Or Print Confirming Results |
| are as recorded. | SCHOL THE | Print ing Re |
| The state of the s | ,500 AUTO 14148 | SE . |
| TECHNICIAN DEAT STT DEVICE: SALIVA DBREATH* 15-Minute Wait: Yes No | E STATE OF THE PROPERTY OF THE PROPERTY AND THE PROPERTY OF TH | 87 13 |
| SCREENING TEST: (For BREATH DEVICE* write in the space below only if the testing device is not designed to print.) | # # # # # # # # # # # # # # # # # # # | Here |
| Test# Testing Device Name Device Serial # QR Lot # & Exp. Date Activation Time Reading Time Result | | |
| CONFIRMATION TEST: Results MUST be affixed to each copy of this form or printed directly onto the form. | | ₩ Affix |
| REMARKS: | | WW XI |
| | | |
| | | amper |
| | | E. E. |
| on Centra 10909 I/O E. | | Tamper Evident Tape |
| Algohol Technician's Company Company Street Address | | ह |
| PRINT) Alcohol Technician's Name (First, M.I., Last) Company City State, Zin | | 4 |
| 713-972-7943 | | Affix Addit |
| Phone Number (Area Code & Number) | | Affix Or F Additional |
| 1 and (orbit) 7-1-09 | | Or P |
| Signature of Alcohol Technician Date Month / Day / Year | | Print d Test |
| STEP 4: TO BE COMPLETED BY EMPLOYEE IF TEST RESULT IS POSITIVE I certify that I have submitted to the alcohol test, the results of which are accurately recorded on this form. I understand that I must not drive, perform safety-sensitive duties, or operate heavy equipment because the results are positive. | | t Results Hen |
| Signature of Employee Date Month / Day / Year | A ACC. WILL TO THE TOTAL TO THE TOTAL TOTA | co . |
| 471-FS-C3 (Rev. 6/01) 6363 | A Affix With Tamper Evident Tape | |

CUSTODY AND CONTROL FORM (DO NOT USE THIS FORM FOR D.O.T. COLLECTIONS) 317793244



| STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIV | E 3560 Air Center Cove, Memphis, TN 38118 (888)222-489 |
|---|--|
| A. Employer Name, Address, I.D. No. | B. MRO Name, Address, Phone and Fax No. |
| Market 1946 St. St. San and W. C. S. 18 months | LEXISHETS - STREET HOTTHAN, MO |
| CMC/TX-Houston 1-10 Sast | 480 QUADRANGLE DRIVE STE A BOLINGBROOK, 11 60440 |
| CES ENVIRONMENTAL | Phone: (855) 794-6574 Fax: (856) 355-1297 |
| 281433-9792 | Employer Prone: |
| C. Donor Information Note: Donor must sign HIPAA authorization on ba | |
| SSN (b) (4) D. Results (c) 3.3.5.5 | -NDOT M/POS REV-CP ()10726-NDOT W/ALL REW-CP |
| | |
| First E. Reason for M.I. | |
| Name Li Pre-e | mployment ☐ Random ☐ Reasonable Suspicion/Cause ccident ☐ Post Injury ☐ Return to Duty ☐ Follow-up |
| Name Last Name H.A. A. A. D. Z. Name | ☐ Other (specify): |
| E Toot to be | e Performed |
| 1 All | CI DRUG ECHESN: 10 PANEL |
| | O4 DRUG NURREN: 19 PANEL |
| Phone (Daytime) | OI F-WIDA: 5 DRUG BANKL (5.15) |
| Donor | 23 DROG SCREEN: 9 PANEL |
| | TOT ALCOHOL UNITE .02/.02 |
| | OBE DRUG SCREEN: B PAMEL W/ Bihanol |
| Donor Certification: | 09 DRUG SCREEN: 10 PANEL (2.50) |
| I certify that I provided my trine specimen to the collector; that I have not adulterated it in any manufer; that each specimen bottle used was sealed with a | |
| tamper-evided seat in the presence, and that the information provided on this temperature on the label affixed to take the specimen bottle is correct. | |
| | |
| Date (MM/DD/YY) | |
| 6 Collection Site Information 703 | is they the report of the first the company of the second |
| SY CONCENTRA MEDICAL CERTERS | |
| 是多数形式食器食品。 全 种学数的 数据,实现积累的 基本。 | te ID # Collection Site Phane No. |
| HOUSTON, TX T7025 | Collection Site Fax Να. |
| STEP 2: COMPLETED BY COLLECTOR | Collection one ray to. |
| Read specimen temperature within 4 minutes. Is temperature between 90° and 100° F? YES NO, enter remarks | Specimen Collection: ☐ Observed: ☐ Observed: ☐ Split (Enter Rémarks Below) |
| REMARKS: | |
| STEP 3: Collector affixes bottle seal(s) to bottle(s). Collector dates seal(s) STEP 4: CHAIN OF CUSTODY - INITIATED BY COLLECTOR AND COMPLE | |
| | ed and released to the Delivery Service noted, in accordance with applicable requirements. |
| Signature of Collector Time of Collection | SPECIMEN BOTTLE(S) RELEASED TO: |
| PRINT Collector's Name (First MI Last) Date (MM/DD/YY) | COUNTR |
| PRINT Collector's Name (First**ML Last) Cate (MM/DD/YY) RECEIVED AT LABORATORY | Name of Delivery Service Transferring Specimen to Laboratory Primary Specimen Bottle Seal SPECIMEN BOTTLE(S) RELEASED TO: |
| x | Intact? |
| Signature of Accessioner | Yes No |
| PRINT Accessioner's Name (First, MI, Last) Date (MM/DDYY) | enter remarks below |

COPY 4 - EMPLOYER COPY

| Alcohol Testing Form (Non-DOT) | | 4 |
|--|--|--|
| (The instructions for completing this form are on the back of Copy 3) | E STATE OF THE STA | Affix Or I |
| STEP 1: TO BE COMPLETED BY ALCOHOL TECHNICIAN | | 8 8 |
| A: Employee Name JOSEPH HERNANDEN | 1 | |
| A: Employee Name (Print) (Prin | | Print Res |
| B: SSN or Employee ID No. | | Tint Results |
| A COLOR STATE OF THE STATE OF T | | Here |
| C: Employer Name CZS. Environ mental | | e |
| Land Die | | |
| Street | | T |
| How. D. 77021 | | 4 |
| 7 | | Affix |
| City, ST ZIP | \$ | 34 |
| DER Name and $\int \int \int \int \int \int \int \int \int \int \int \int \int \int \int \int \int \int \int$ | | NI. |
| Telephone No. 1 Tac Nales / Manguelle 5/400/19 | | With Tamps |
| DER Name DER (Area Code & Phone Number) | | |
| D: Reason for Test: Random Reasonable Susp. Post-Accident Return to Duty. Follow-up Pre-employment | | |
| STEP 2: TO BE COMPLETED BY EMPLOYEE | | Evident |
| I certify that I am about to submit to alcohol testing and that the identifying information provided on the form is | The state of the s | d |
| true and correct | | |
| Still (| ALTOMONITOR CC COLISS | Tape |
| 7-1-09 | 27.41.74B | |
| Signature of Employee Date Month / Day / Year | TEST NO. 711 | 46 |
| STEP 3:/TO BE COMPLETED BY ALCOHOL TECHNICIAN | roy. Horytagos | Affix Or Print Confirming Results |
| (If the technician conducting the screening test is not the same technician who will be conducting the | ြောက်ကြေက မံမြိမ်မြို့ သည် မြိန်သည် စေသော စစေသည်။ မြို့ | |
| confirmation test, each technician must complete their own form.) I certify that I have conducted alcohol testing on the above named individual, that I am qualified to operate the testing device(s) identified, and that the results | SOMETHING TEST | Or Print |
| are as recorded. | 3/210L TIME | |
| | .000 AUTO 14:48 | 183 |
| TECHNICIAN BAT STT DEVICE: SALIVA BREATH* 15-Minute Wait: Yes No | and charles are another parameters and a supplying parameters are a supplying the same of the supplying the same of the supplying the same of the supplying the same of the supplying the same of the supplying the same of the supplying the same of the supplying the same of the supplying the same of the supplying the same of the supplying the same of the supplying the same of the supplying the same of the supplying the same of the supplying the same of the supplying the same of the supplying the same of the supplying the same of the supplying the supplying the same of the supplying the | |
| SCREENING TEST: (For BREATH DEVICE* write in the space below only if the testing device is not designed to print.) | Participant of the second | He |
| | | ED '' |
| Test# Testing Device Name Device Serial # OR Lot # & Exp. Date Activation Time Reading Time Result | | |
| | | 4 |
| CONFIRMATION TEST: Results MUST be affixed to each copy of this form or printed directly onto the form: | | |
| | | |
| REMARKS: | | MiW |
| | | |
| | | a de la composição de l |
| | | |
| | | Tamper Evident |
| <u> </u> | | en |
| 10909 TIOS. | THE STATE OF THE S | Tape |
| Alcohol Technician's Company Company Street Address | ## 1 | 17 |
| DAVID (ORBEH How, Tr. 77029 | grade able to are \$10. The set (00 EX acc gar gar and are (a), able gar gar gar are and able for all \$200 per 100 EX (acc gar gar are and any able gar fill able for all \$200 per 100 | . |
| (PRINT) Alcohol Technician's Name (First, M.I., Last) Company City, State, Zip | | 3 |
| Phone Number (Area Code & Number) | | Affix Or P Additional |
| 7-1-09 | | 1 Q |
| Signature of Alcohol Technician Date Month / Day / Year | | Affix Or Print Additional Tes |
| | | int Test |
| STEP 4: TO BE COMPLETED BY EMPLOYEE IF TEST RESULT IS POSITIVE | | |
| I certify that I have submitted to the alcohol test, the results of which are accurately recorded on this form. I understand that I must not drive, perform safety-sensitive duties, or operate heavy equipment because the | | Rosnis |
| results are positive. | | |
| | | Here |
| Signature of Employee Date Month / Day / Year | Affix With Tamper Evident Tap | |
| 471-FS-C3 (Rev. 6/01) 6363 | • | |

CUSTODY AND CONTROL FORM (DO NOT USE THIS FORM FOR D.O.T. COLLECTIONS) 317793244



ADVANCED TOXICOLOGY NETWORK,

| STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER RE | PRESENTATIVE | B. MRO Name, Address, Pi | hono and Eav No |
|--|-----------------|--|--|
| A. Employer Name, Address, I.D. No. * 情意意識 | | | STORY BETWEE, MD |
| CMC/TX-Mousion I-15 East | * | 480 OMDRASCU | |
| CES ENVIRONMENT | AL. | EGHTFRERESCK: | IL 66440 |
| C. E. B. Con A to Age of the Control | | | \$4-6074 Fax: (664)955-1987 |
| 281433-9792 | | Mapleyer Shene! | |
| C. Donor Information Note: Donor must sign HIPAA auth | | | |
| SSN (4) | D. Results Re | | |
| First The state of the state of | E. Reason for | Test | |
| First A PA MI. | ☐ Pre-em | ployment | m 🔲 Reasonable Suspicion/Cau |
| | - Post Acc | ident D Post Injury | ☐ Return to Duty ☐ Follow-up |
| Last HERMANDEZ | | Other (specify); | |
| Alt | F. Test to be I | Performed: | |
| ID | | 1 AMUG CCAMER: 10 | PRINCL |
| Donor (a) (a) | 3 | 4 DAUG ROREEN: 10 | |
| Phone (a) | | i z-mida: A ches : | |
| (*(Daytime) | * * * | Tinos ocheen 9 i | · · · · · · · · · · · · · · · · · · · |
| Donor | | 67 ALCOHOL BRIDE | |
| (Evening) (optional) | , , | 92 DAVS BORSEN: 8 | |
| Donor Certification: | | A dring screen: 10 | |
| Legrify that I provided mysurine specimen to the collector; that I have not | 1 1 months | ago anticomor or war actions as a sec- | to the time of the state of the |
| adulterated it in any manner; that each specimen bottle used was sealed with a | | | |
| tamper-evident seal in my presence; and that the information provided on this series and on the label affixed to take specimen bottle is correct. | | Y | • |
| | | entropy to the control of the control of the control of the control of the control of the control of the control of the the control of the co | |
| Signature of October Deate (MM/DD/YY) | • | | |
| G. Collection Site Information | 25 26 36 | <u> </u> | |
| OF CONCERTER MEDICAL CENTERS | T Call | | (713) 973-7343 |
| 200 10806 T-10 PART PREFERV | Site | ID# | Collection Site Phone No. |
| HOUSTON, THE PROZE | | • | (713) 673-7947 |
| | | <u> </u> | Collection Site Fax No. |
| STEP 2: COMPLETED BY COLLECTOR | · _ · | | |
| Read specimen temperature within 4 minutes. Is temperature be 90° and 100° F? YES NO, enter remarks | ∍tween | Specimen Collection: | ☐ Observed; ☐ Split (Enter Remarks Below) |
| REMARKS: | | in the second second | |
| STEP 3: Collector affixes bottle seal(s) to bottle(s). Collector STEP 4: CHAIN OF CUSTODY - INITIATED BY COLLECTOR | | | |
| I certify that the specimen given to me by the donor identified above was coll | AM . | | |
| X Signature of Collection Time of Collection | <u>~PM</u> → | SPECIMEN BOTTLE(S) RELE | EASED TO: |
| | - m | COUNI | |
| PRINT Collector's Name (First MI Lest) Date (MM/DD/YY | 7 | Name of Delive | ery Service Transferring Specimen to Laboratory |
| RECEIVED AT LABORATORY | 4 | Primary Specimen Bottle Seal | SPECIMEN BOTTLE(S) RELEASED TO: |
| .v | | Intact? | |
| X | | Voc No | · |
| X Signature of Accessioner | | Yes No | Temporary Storega |

COPY 5 - DONOR COPY

| | Patient Information | Treating Provider | Discharge Instructions |
|---|----------------------|--|---------------------------------|
| BAYSHORE | HERNANDEZ, JÖSEPH P. | Cherryll LeBlanc M.D. | Date: 6/30/09 Time: 11:39:37 PM |
| med[cateenter] Bayshore Medical Center 4000 Spencer Hwy, Pasadena, TX 77504 | Phone: | 4000 Spencer Hwy, Pasadena, TX 77504 Phone: 713-359-1440 | Patient Copy |
| • | | | Page: 1 of 1 |

Patient Discharge Instructions

Document: 522

HIGH BLOOD PRESSURE - NEW TO BE CONFIRMED

Your blood pressure was higher today than normal. Sometimes anxiety or pain can cause a temporary rise in blood pressure those later returns to normal. An elevated blood pressure on one measurement does not mean that you have hypertension (a chronic illness). However, you must have your blood pressure measured again within the next few days to find out if your blood pressure is still high.

Follow up: A repeat blood pressure measurement can be done at your doctor's office or this facility. Some pharmacies and grocery stores offer automated blood pressure machines for your use.

If the measurements are high on 2 out of 3 days, you will need to follow up with your doctor for further evaluation and treatment.

DO NOT PUT THIS OFF! Untreated high blood pressure increases the risk for heart attack and stroke. It is a treatable condition and may respond to such simple measures as diet and lifestyle changes.

Return to this facility immediately or contact your doctor if you begin to have any of the following:

- Chest pain or shortness of breath.
- Moderate to severe headache.
- Weakness in the muscles of the face, arms or legs.
- Difficulty with speech.
- Extreme drowsiness, confusion, fainting or dizziness.
- Pulsating or rushing sound in the ears.

Discharge Instructions Special Notes

I understand that the emergency care which I received is not intended to be complete and definitive medical care and treatment. EKG"s, X-rays, and lab studies will be reviewed by appropriate specialists and I will be notified of significant discrepancies. If your sysmptoms persist or worsen, please follow-up with your primary physician or return to the Emergency Department.

| BAYSHORE medical center Bayshore Medical Center 4000 Spencer Hwy, Pasadena, TX | | Patient Inform HERNANDEZ, ID: 738801 Reg: 015084273 | JOSEPH P. | Treating Provider Cherryll LeBlanc M.D. 4000 Spencer Hwy, Pasadena, TX 77504 Phone: 713-359-1440 | Date: | charge Summary 6/30/09 Time: 11:39:42 PM Patient Copy |
|--|---|--|---------------|--|-------------|---|
| 1) Your Discharge Instruction | | 0.75 | 2) Your Pr | escriptions: | | |
| HYPERTENSION - TO BE CONFIF | RMED #Document: 52 | 2 (English) | | • | | |
| | • | | | | | |
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| | | | | | | |
| , | | | 1 | | | |
| | | | | | | |
| 3) You should Follow Up with | | | <u> </u> | | | |
| Follow Up Physician: | Follow Up Inform | ation | | | | |
| YOUR REGULAR PHYSICIAN, | On 06/30/2009 this p 4000 Spencer Hwy, | patient was treate Pasadena, TX 77 | 504 for Refer | gency Department at Ba to Discharge list above s persist or worsen, plea | The patient | was asked to follow up |
| Phone: | Department for evalu | uation. | | | | |

I understand that the emergency care which I received is not intended to be complete and definitive medical care and treatment. Lacknowledge that I have been instructed to contact the above physician immediately for continued and complete medical diagnosis, care and treatment. EKG's, X-rays, and lab studies will be reviewed by appropriate specialists and I will be notified of significant discrepancies. I also understand that my signature authorizes this Medical Center to release all or any part of my medical record (including, if applicable, information pertaining to AIDS and/or HIV testing, mental health records, and drug and/or alcohol treatment) to the referred physician listed above.

Claim Number:

Work:

Concentra Medical Centers

10909 East Frwy Houston, TX 77029 Phone: (713) 973-7943 Fax: (713) 973-7947

Service Date: 07/01/2009

Case Date: 06/26/2009

Physician Activity Status Report

Hernandez, Joseph Patient: SSN: XXX-XX(b) Address: Home:

Employer Location: CES Environmental

Address:

4904 Griggs Rd

Contact: Prabhakar Thangudu Role: DER/Primary

Auth. by:

Houston, TX 770213208

Phone: (281) 433-9792 Ext.:

(713) 676-1676 Fax:

This Visit: Time In: 02:28 pm Time Out: 03:23 pm Recordable: N/A

Treating Provider: Jean T. Dolan, MD

Diagnosis: 992.5 Heat Exhaustion, Unspecified

Ext.:

Visit Type: New

Medications:

☐ Dispensed Prescription Medication to Patient

☐ Dispensed Over-The-Counter Prescription

Patient Status:

Regular Activity - Released from care

Return to regular duty on 07/01/2009

Remarks:

Employer Notice:

The prescribed activity recommendations are suggested guidelines to assist in the patient's treatment and rehabilitation. Your employee has been informed that the activity prescription is expected to be followed at work and away from work.

Anticipated Date of Maximum Medical Improvement:

Actual Date of Maximum Medical Improvement: 07/01/2009

Next Visit(s):

Patient Notice: It is essential to your recovery that you keep your scheduled appointments, but should you need to reschedule or cancel your appointment, please contact the clinic. Thank you for your cooperation.

To: Dan Bowman 7136761676

Employee - You are required to report your injury to your employer within 30 days if your employer has workers' compensation insurance. You have the right to free assistance from the Texas Workers' Compensation Commission and May be entitled to certain medical, and income benefits. For further information call your local



Trabajador - Es necesario que ustad reporte su lesión a su empleador dentro de 30 días a partir del día en que es leatonó, al au empleador tiene aeguro de compensación para trabajadores. Ila Comisión Tejana de Compensación para Trabajadores le ofrece saistencia gratuita, también puede que usted tenga derecho la clertos beneficios médicos y monetarios. Para mayor

| Commission field office | • | (ERS' COMPENSATIO | | i la ôficina logal de la Comileión 1-800 ATUS REPORT | J-252-7031 |
|---|--|--|---|---|---|
| PART I: GENERAL INFORMATION | | C. Damada Marra and Dasses | | (for fransmission purposes only) | Date Being Sent |
| | | 9. Employer's Name | | | |
| Joseph Hernandez | | CMC - Houston I-10 East | | CES Environmental | |
| | Social Security Number | 7. Clinic/Fedility/Doctor Phone & Fax (713)973-7943 (713)9 | 979-7947 | 10. Employer's Fax # or Email (713)676-1676 | Address (If known) |
| 4. Employee's Descript | • • | 8. Clinic/Facility/Doctor Address (street add | reas) | 11, inaurance Carrier | |
| Patient states :"I was stomach stared hur | is over heated and my head and line " | | | Texas Mutual Insurance C | |
| | ig. | City State Zip Houston TX 779 | 029 | Carrier's Fax # or Email A: (512)224-3669 | teres (II known) |
| | | | | | |
| | | DN (FULLY COMPLETE ONLINGER) resulting from the workers' compe | | ES AND DESCRIPTION IN 10(| c) AS APPLICABLE) |
| X (a) will allow will allow expected (c) has prevented through | the employee to return to the employee to return to the distribution of the less through ented and still prevents the enterties (date). The following the enterties of the enter | work as of 07/01/2009 (date) y work as of(date) y(date). mplayee from returning to work lowing describes how this injury | vithout reatrictiona, vith the reatrictiona (as of preventa the emplo | Identified in PART III, v | a cantinue |
| PART III: ACT | IVITY RESTRICTIONS' | (REQUIRED IF BOX 13(b) IS | CHECKED) | | |
| Max Hours per d Standing Sitting Kneeling/Squatti Bending/Stoopin Pushing/Pulling Twisting Other: | ng | Walking Climbing stairs/ladders Grasping/Squeezing Wrist flexion/extension Reaching Overhead Reaching Keyboarding | 2 4 6 6 Other | Sit/Stretch bre Must wear spli Must use cruto No driving/ope Can only drive No work/ in extreme st heights Must keep Elevated No skin contact | r day of work: r day of work: reaks ofper int/cast at work ches at all times erating heavy equipment automatic transmissionhours/day work: hot/cold environments or on scaffolding Clean & Dry ct with: ges necessary at work |
| | STRICTIONS (If any): | ************************************** | | 20. MEDICATION | RESTRICTIONS(# any): cription medication(s) |
| These restrictions are based on the doctor's best understanding of the employee's essential job functions. If a particular setriction does not apply, it should be disregarded. If modified duty that meets these restrictions is not available, the patien should be considered to be off work. Note - these restrictions should be followed outside of work as well as at work. Advised to take over-the-counter meds Medication may make drowsy (possible safety/driving issues) | | | | | |
| | | PPOINTMENT INFORMATIO | | | |
| 21. Work injury Diagnosis Information: 22. Expected Follow-up Services Include: | | | | | |
| 992 b Heat Expansion Unapacitied | | | | | |
| Referral to/Consult withon | | | | e) stam/pm | |
| | | Special studies (list): | | | e) at am/pm |
| | | None. This is the last scheduled | visit for this problem | | |
| Date / Time of Visit | EMPLOYEE'S SIGNATURE | DOCTOR'S SIGNATURE | Visit Type: | Role of Doctor: | ▼ Treating doctor |
| 07/01/2009 02:28 pn | | Hamis A. a. | ☑ Inhial | Designated doctor | Referral doctor |
| Diacharga Time 37/01/2009 09:29 pn | | Jeonie Dolan | ☐ Follow-up | Carrier-selected RME DWC-selected RME | ☐ Consulting doctor☐ Other doctor |

To: Prabhakar Thangudu 7136761676

Employee - You are required to report your injury to your employer within 30 days if your employer has workers' compensation insurance. You have the right to tree seletance from the Texas Workers' Compensation Commission and may be entitled to certain medical and income benefits. For further information call your local Commission field office or 1(800)-252-7031.



Trabajador - Es naceserio que usted reporte su lación a su empleador dentro de 30 días a partir del día an que se lesiono, al su empleador tiene aeguro de compensación para trabajadores. Ila Comisión Tejana de Compensación para Trabajadores la ofrace saletencia gratulta, también puede que usted tengs derecho la ciertos beneficios mácicos y monetarios. Para mayor información llame a la oficina local de la Comisión 1-800-252-7031.

| TEVAQ MADVEDQI | COMPENSATION WORK STATUS | DEDADT |
|-----------------|---------------------------------|--------|
| ICYAO MAGEMENO. | CUMPENSATION WORK STATUS | REPURI |

| PART 1: GENERAL INFORMATION S. Doctor's Name and Degree Jean T. Dolan, MD | | purposes only) | | |
|--|---|---|--|--|
| 1 Injured Employee's Name | 6. Clinic/Facility Name | 9. Employer's Name | | |
| Uoseph Hernandez 2. Date of Injury [3, Sodel Security Number | GMC - Houston I-10 East 7. Clinic/Facility/Degler Phone & Fax | CES Environmental | | |
| 06/26/2009 XXX-XX | 7. Clinic/Fedilly/Dodor Fnone & Fex (713)973-7947 | 10. Employer's Fax # or Email Address (li known) (713)676-1676 | | |
| | 8. Clinic/Facility/Doctor Address (street address) | 11. Insurance Carrier | | |
| Patient states:"I was over heated and my head and | 10909 East Frwy | Texas Mutuel Insurance Company | | |
| stomach stered hurting." | City State Zip | 12. Carrier's Fax # or Email Address (if known) | | |
| | Houston TX 77029 | (512)224-3669 | | |
| PART II: WORK STATUS INFORMATION (FULLY COMPLETE ONLINCTUDING ESTIMATED DATES AND DESCRIPTION IN 13(c) AS APPLICABLE) 13. The injured employee's medical condition resulting from the workers' compensation injury: X (a) will allow the employee to return to work as of 07/01/2009 (date) without restrictions. (b) will allow the employee to return to work as of (date) with the restrictions Identified in PART III, which are expected to last through (date). (c) has prevented and still prevents the employee from returning to work as of (date) and is expected to continue through (date). The following describes how this injury prevents the employee from returning to work: PART III: ACTIVITY RESTRICTIONS* (REQUIRED IF BOX 13(b) IS CHECKED) | | | | |
| 14. POSTURE RESTRICTIONS (If any) : | 17. MOTION RESTRICTIONS (If any): | 19. MISC. RESTRICTIONS (If any): | | |
| Max Hours per day: 0 2 4 6 6 Other | | Max hours per day of work: | | |
| | Walking PDDDD | | | |
| Standing | | Sit/Stretch breaks ofper | | |
| Sitting UUUU | Climbing stairs/ladders | Must wear splint/cast at work | | |
| Kneeling/Squatting | Grasping/Squeezing | Must use crutches at all times | | |
| Bending/Stooping | Wrist flexion/extension | No driving/operating heavy equipment | | |
| Pushing/Pulling | Reaching | Can only drive automatic transmission | | |
| Twisting | Overhead Reaching | No work/hours/day work: | | |
| | · | | | |
| Other: | Keyboarding | in extreme hot/cold environments | | |
| 15. RESTRICTIONS SPECIFIC TO (If applica | ble): Other: | at heights or on scaffolding | | |
| ☐ L Hand/Wrist ☐ R Hand/Wrist | 18. LIFT/CARRY RESTRICTIONS (If any): | Must keep | | |
| | ock May not lift/carry objects more thanlbs | ☐ Elevated ☐ Clean & Dry | | |
| | ack for more thanhours per day | No skin contact with: | | |
| | | | | |
| L Foot/Ankle R Foot/Ankle | May not perform any lifting/carrying | Dressing changes necessary at work | | |
| Other: | Other: | No running | | |
| 16. OTHER RESTRICTIONS (If any): | • | 20. MEDICATION RESTRICTIONS(If any): | | |
| | | Must take prescription medication(s) | | |
| | | Advised to take over-the-counter meds | | |
| "These restrictions are based on the doctor's best understanding of the employee's essential job functions. If a particular restriction does not apply, it should be disregarded. If modified duty that meets these restrictions is not available, the patien safety/driving issues) Medication may make drowsy (possible restriction be off work. Note - these restrictions should be followed outside of work as well as at work. | | | | |
| PART IV: TREATMENT/FOLLOW-UP AP | | | | |
| | Expected Follow-up Services Include: | | | |
| | Evaluation by the treating doctor on | (date) at am/pm | | |
| | Referral to/Consult withon | (date) atam/pm | | |
| The state of the s | Physical medicineX per week forweeks starting | on (date) at am/pm | | |
| | | t this time, no further medical care is anticipated | | |
| Date / Time of Visit EMPLOYEE'S SIGNATURE | | e of Daglor: K Treating doctor | | |
| 07/01/2009 02:2 0 pm | | Designated doctor Referred doctor | | |
| Diacharge Time | \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ | Carrier-selected RME | | |
| 07/01/2009 03:23 pm | Tours of L | DWC-selected HME Other doctor | | |

DIVISION OF WORKERS' COMPENSATION

Authorization for Release of Records

In accordance with the provisions of the Fair Credit Reporting Act (Public Law 91-508), as amended by the Consumer Credit Reporting Act of 1996 (Title II, Subtitle D, Chapter I, of Public Law 104-208), you are being informed that a consumer report may be obtained on you for employment purposes.

In addition, may also request additional reports for the purposes of investigation as required by Section 391.23 of the Federal Motor Carrier Safety Regulations.

My signature below indicates that you are authorized to provide such reports and are released from any and all liability which may result from furnishing such information.

I acknowledge the receipt of the above disclosure and authorize to obtain reports and conduct investigations on me for employment purposes. The authorization is ongoing in the event such a report is needed in the future. X 9/1/04

In accordance with the provisions of the Fair Credit Reporting Act (Public Law 91-508), I hereby certify that the information requested below will be used for "permission purposes" as defined in the Act.

Furthermore, if the applicant named below is denied employment based on the information received. I will identify the source of the report in accordance with the Act.

(Applicant's Aignature)

| (Signature of Requestor) Probhakor R. Thangudu, HSE Managa (Printed Name & Title) | (Name of Company) (Number & Street) | | Environmental Services 4904 Griggs Rd. Houston, TX 77021 (713) 676-1460 |
|--|---|--|--|
| (Date) | (City, State & Zip Code) | | _ |
| ^** | | | |
| Applicant: K JOSEPH HEMSINDER | MMADDARONERS voltagistik kirilik kandisakan berapunan kirila kanapuh garup voga kana Masa | in distribution de la companya de la companya de la companya de la companya de la companya de la companya de l | -monthlyses between the colorise special 400 in 400 in including the service special colorise in colorise special colorise in the colorise special colorise in the colorise special colorise in the colorise special colorise in the colorise special colorise in the colorise special |
| Address: (Number X (b) (4) | City: (4) | State × (b) | (4) |
| Former Address: Number & Street) | City: | State (b) (4 & Zip | |
| | | | - A 5-4-4 |
| SN; 185-33-6708 License X Number: 1736 535 3 | State: X | Γχ | DOB ×1936-7 |

Revised: 8/21/2005

OSHA's Form 301 **Injuries and Illnesses Incident Report**

Information about the employee Joseph Hernandez

1) Full Name

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

Information about the case

10) Case number from the Log

U.S. Department of Labor

Occupational Safety and Health Administration

1 (Transfer the case number from the Log after you record the case.)

Form approved OMB no. 1218-0176

This Injury and Illness incident Report is one of the first forms you must fill out when a recordable work-

| elated injury or illness has occurred. Together with he Log of Work-Related injuries and illnesses and he accompanying Summary, these forms help the implyer and OSHA develop a picture of the extent nd severity of work-related incidents. Within 7 calendar days after you receive information that a recordable work-related injury or liness has occurred, you must fill out this form or an | 2) Street City 3) Date of birth 4) Date hired 5) X Male | 11) 2) 3) 14) | Date of injury or illness 6/30/2009 Time employee began work 6:00 AM AM/PM AM Time of event AM/PM X Check if time cannot be determined What was the employee doing just before the incident occurred? Describe the activity, as well at the tools, equipment or material the employee was using. Be specific. Examples: "climbing a ladder while carrying roofing materiels"; "spraying chlorine from hand sprayer"; "daily computer key-entry." |
|--|---|------------------------|---|
| quivalent. Some state workers' compensation, nsurance, or other reports may be acceptable substitutes. To be considered an equivalent form, my substitute must contain all the information | ☐ Female Information about the physician or other health care professional | 451 | Cleaning out tank NV1 At Paces |
| According to Public Law 91-596 and 29 CFR 904, OSHA's recordkeeping rule, you must keep his form on file for 5 years following the year to which it pertains If you need additional copies of this form, you | Name of physician or other health care professional Concentra If treatment was given away from the worksite, where was it given? | 15) | What happened? Tell us how the injury occurred. Examples: "When ladder slipped on wet floor, worker fell 20 feel"; "Worker was spayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time." employee got over heated |
| nay photocopy and use as many as you need. | Facility Concentra Street 10909 East Frwy City Houston State TX Zip 77029 | 16) | What was the injury or illness? Tell us the part of the body that was affected and how it was affected; be more specific than "hurt", "pain", or "sore." Examples: "strained back"; "chemical burn, hand": "carpal tunnel syndrome." heat exhaustion |
| Completed by Prabhakar R. Thangudu Title HSE Manager | 8) Was employee treated in an emergency room? Yes No 9) Was employee hospitalized overnight as an in-patient? | 17) | What object or substance directly harmed the employee? Examples: "concrete floor"; "chlorine"; "radial arm saw." If this question does not apply to the incident, leave it blank. Heat |
| Phone 713-676-1460 Date | LYes X_No | 18) | If the employee died, when did death occur? Date of death |
| | | | |

Public reporting burden for this collection of information is estimated to average 22 minutes per response, including time for reviewing instructions, searching existing data sources, gethering and maintaining the data needed, and completing and reviewing the collection of information. Persons are not required to respond to the collection of information unless it displays a current valid OMB control number. If you have any comments about this estimate or any other aspects of this data collection, including suggestions for reducing this burden, contact: US Department of Labor, OSHA Office of Statistics, Room N-3644, 200 Constitution Ave, NW, Washington, DC 20210. Do not send the completed forms to this office.



| CLAIM# | | | |
|----------|---|--|--|
| Carrier# | • | | |
| | | | |

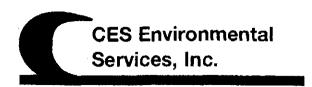
SUPPLEMENTAL REPORT OF INJURY

| Part EMPLOYER INFORMATION | | |
|--|--|---|
| 1. Employer business name CES Envisonment | Services. Inc | 2. Employer phone # 713 - 676 - 1460 |
| 3. Employer mailing address Road, | Houston, Tx 77021 | |
| 4. Insurance carrier name Texas Mutud | | |
| | RTW) opportunities available based on the injured work d phone # | rer's current capabilities? yes no no |
| 6. Has the insurance carrier provided RTW c | coordination services within the past 12 months? yes | Dateno |
| 7. Has the employer requested RTW training | from DWC or the insurance carrier? yes | no 🔲 |
| 8. Has the insurance carrier provided acciden | nt prevention services in the past 12 months? yes | Date ກບ |
| 9. Has the employer requested accident prev | vention services from the insurance carrier? yes | no |
| Part II REASON FOR FILING THIS | REPORT (deadlines vary, see instruction | ns) |
| b. The injured worker is earning of c. The injured worker returned, the | work in either a full or limited capacity: File this report more or less than the pre-injury wage because of the in hen later had additional lost time or reduced wages as r was terminated from employment: File within 10 days | njury: File within 10 days. a result of the injury: File within 3 days. |
| Part III INJURED WORKER INFOR | | |
| HERNANDEZ, Just | 12. SSN (last 4 digits) E PH | 4) 13. DOI |
| 14. Injured worker mailing address and phone (0) (4) | 9# | |
| 15. Thist day or lost time or reduced | 10. First day or addition | al lost time |
| wages for this injury (mm/dd/yyyy) | or reduced wages (r | mm/dd/yyyy) N A |
| | Of Todaced Wages (1 | |
| | s (cumulative) of lost time or reduced wages as a resul | |
| 17, Has the injured worker experienced 8 day | s (cumulative) of lost time or reduced wages as a resul | It of the injury? yes no |
| 17, Has the injured worker experienced 8 day If yes, the date of the 8 th day (mm/dd/yyyy | s (cumulative) of lost time or reduced wages as a resul | or died? |
| 17, Has the injured worker experienced 8 day If yes, the date of the 8th day (mm/dd/yyyy 18. Date of most recent RTW | s (cumulative) of lost time or reduced wages as a result) 19. Has the injured worker resigned, been terminated | or died? |
| 17, Has the injured worker experienced 8 day If yes, the date of the 8th day (mm/dd/yyyy 18. Date of most recent RTW | (cumulative) of lost time or reduced wages as a result () 19. Has the injured worker resigned, been terminated date of resignation date of termination | or died? yes no on date of death |
| 17, Has the injured worker experienced 8 day If yes, the date of the 8th day (mm/dd/yyyy) 18. Date of most recent RTW Full duty, full pay Limited duty, full pay Limited duty, reduced pay 20. Hours the injured worker was working dur | 19a. Reason for resignation/termination 19b. Was the injured worker on limited duty when terminated | or died? yes no yes no yes no yes no yes no yes no yes no yes no yes no yes no yes no yes no yes no yes no yes no yes no yes no yes no yes no yes |
| 17, Has the injured worker experienced 8 day If yes, the date of the 8th day (mm/dd/yyyy 18. Date of most recent RTW | 19. Has the injured worker resigned, been terminated date of resignation date of termination 19b. Was the injured worker on limited duty when term | or died? yes no |
| 17, Has the injured worker experienced 8 day If yes, the date of the 8th day (mm/dd/yyyy) 18. Date of most recent RTW Full duty, full pay Limited duty, full pay Limited duty, reduced pay 20. Hours the injured worker was working dur | 19. Has the injured worker resigned, been terminated date of resignation date of termination | or died? date of death injurated? yes no date of death yes no yes no finated? yes no |
| 17, Has the injured worker experienced 8 day If yes, the date of the 8th day (mm/dd/yyyy) 18. Date of most recent RTW | 19. Has the injured worker resigned, been terminated date of resignation date of termination date of termination 19b. Was the injured worker on limited duty when terming the pay period of 21. Weekly/hourly earning the pay period of 21. Weekly/hourly earning the pay period of 21. Weekly/hourly earning the pay period of 21. Weekly/hourly earning the pay period of 21. Weekly/hourly earning the pay period of 21. Weekly/hourly earning the pay period of 21. Weekly/hourly earning the pay period of 21. Weekly/hourly earning the pay period of 21. Weekly/hourly earning the pay period of 21. Weekly/hourly earning the pay period of | or died? date of death injurated? yes no date of death yes no yes no finated? yes no |
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| 17, Has the injured worker experienced 8 day If yes, the date of the 8th day (mm/dd/yyyy) 18. Date of most recent RTW AAA Full duty, full pay Limited duty, full pay Limited duty, reduced pay 20. Hours the injured worker was working dure 6-21-09 to 6-27-09: Indicated hours are: Increase from pre-injury Same as pre-injury Decrease from pre-injury | 19. Has the injured worker resigned, been terminated date of resignation date of termination 19b. Was the injured worker on limited duty when terming the pay period of 21. Weekly/hourly earning the pay period of 21. Weekly/hourly earning the pay period of 21. Weekly/hourly earning the pay period of 21. Weekly/hourly earning the pay period of 21. Weekly/hourly earning the pay period of 21. Weekly/hourly earning the pay period of 21. Weekly/hourly earning the pay period of | or died? yes no or died? |
| 17, Has the injured worker experienced 8 day If yes, the date of the 8th day (mm/dd/yyyy) 18. Date of most recent RTW AAA Full duty, full pay Limited duty, full pay Limited duty, reduced pay 20. Hours the injured worker was working dure 6-21-09 to 6-27-09: Indicated hours are: Increase from pre-injury Same as pre-injury Decrease from pre-injury | 19. Has the injured worker resigned, been terminated date of resignation date of termination 19b. Was the injured worker on limited duty when terming the pay period of 21. Weekly/hourly earning to 21. Weekly/hourly earning to 227-09:\$ Indicated wages are: Increase for Same a property of Same a property of Same appropriate or reduced wages as a result of and and are supported to and | or died? yes no or died? |
| 17, Has the injured worker experienced 8 day If yes, the date of the 8th day (mm/dd/yyyy) 18. Date of most recent RTW | 19. Has the injured worker resigned, been terminated date of resignation date of termination date of termination 19b. Was the injured worker on limited duty when terming the pay period of 21. Weekly/hourly earning the pay period of 21. Weekly/hourly earning the pay period of 21. Weekly/hourly earning the pay period of 21. Weekly/hourly earning the pay period of 21. Weekly/hourly earning the pay period of 21. Weekly/hourly earning the pay period of 21. Weekly/hourly earning the pay period of 21. Weekly/hourly earning the pay period of 22. Undicated wages are: Indicated wages are: | or died? yes no yes yes yes no yes yes yes yes yes yes yes yes yes yes |
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| 17, Has the injured worker experienced 8 day If yes, the date of the 8th day (mm/dd/yyyy) 18. Date of most recent RTW | 19. Has the injured worker resigned, been terminated date of resignation date of termination date of termination 19b. Was the injured worker on limited duty when terming the pay period of 21. Weekly/hourly earning the pay period of 21. Weekly/hourly earning the pay period of 21. Weekly/hourly earning the pay period of 21. Weekly/hourly earning the pay period of 21. Weekly/hourly earning the pay period of 21. Weekly/hourly earning the pay period of 21. Weekly/hourly earning the pay period of 21. Weekly/hourly earning the pay period of 22. Undicated wages are: Indicated wages are: | or died? yes no yes yes yes no yes yes yes yes yes yes yes yes yes yes |



DWC FORM-6 (Rev. 10/05) Page J

DIVISION OF WORKERS' COMPENSATION



4904 Griggs Road Houston, TX 77021 Phone: (713) 676-1460 Fax: (713) 676-1676

Fax

| Ms. Everyn | From: | Prabhakar R. Thangudu | | | | | |
|-------------|-------|----------------------------|-------------|--|--|--|--|
| ius. Everyn | | (b) (4) |] | | | | |
| | | Email: pthangudu@cesenviro | nmental.com | | | | |

Fax: 512-224-3889 Pages:

Phone: Date: 7-13-09

RE: JOSEPH HERNANDEZ

SS # (b) (4)

****** -IND. XMT Journal- ********** Date JUL-13-2009 **** Time 15:48 *******

Date/Time = JUL-13-2009 15:47

Journal No. = 150

Comm. Result = OK

Page(s) = 002

Duration

= 00:00:34

File No.

= 787

Mode

= Memory Transmission

Destination = 15122243889

Received ID =

Resolution = Fine

-CES ENVIROMENTAL -

***** DP-C264 *************

_ ***** _

7137488664- *******

Advanced Toxicology Network 4900 Outland Center Dr Ste 103 Memphis, TN 381186572 (888) 290-1150

UDS Result Form Result Information

Center:

CMC - Houston I-10 East

Address:

10909 East Frwy

City:

Houston, TX 77029

Attn:

CMC/TX-HOUSTON I-10 EAST

Patient Name :

Patient SSN: Profile:

DRUG SCREEN: 10 PANEL

Reason:

Post Accident

Rejection:

Date Collected: 07/01/2009

Date Received: 07/01/2009

Time: 2:55 PM

Time: 11:40 PM

Date Reported: 07/02/2009

Time: 1:40 AM

Creatinine:

Ph:

Specific Grav:

Specimen ID:

Result:

Status:

Sub Acct:

Location:

Mail Address:

| Screened | Summary |
|----------|---------|
|----------|---------|

| | creened outlinary | |
|-----------------|-------------------|---------------|
| Drug | Cutoff/GCMS | Cutoff/Screen |
| Amphetamine | 500 | 1000 |
| Barbiturates | 200 | 300 |
| Benzodiazepines | 200 | 300 |
| Benzoyleogonine | 150 | 300 |
| Carboxy-THC | 15 | 50 |
| Methadone | 200 | 300 |
| Methaqualone | 200 | 300 |
| Opiates | 2000 | 2000 |
| Propoxyphene | 200 | 300 |
| Phencyclidine | 25 | 25 |

Comment Summary

NEGATIVE

Reported

NDOT

Contact Name: Prabhakar Thangudu

CES Environmental

Houston,TX 770213208

4904 Griggs Rd

Comment

Result Summary

Janet Putnam, Lab Director



07/08/2009

C E S ENVIRONMENTAL SERVICES I 4904 GRIGGS RD HOUSTON TX 77021-3208

Notification Confirming Receipt of Claim

Date of Injury:

06/26/2009

Injured Worker:

HERNANDEZ, JOSEPH

Claim Number:

(D) (4) 0001086044

Policy Number:

Attached is a copy of the information another party reported to Texas Mutual Insurance Company which was used to establish this claim. You may submit additional claim information to Texas Mutual Insurance Company. If you have questions regarding this report of injury please contact us at (800) 859-5995.

If your policy includes our workers' compensation health care network option you are required by law to obtain a second Employee Acknowledgement of Workers' Compensation Network Form signed by the injured worker. Please submit a copy of the signed, second acknowledgement form to Texas Mutual Insurance Company. You can find a copy of the form online at www.texasmutual.com/hcn/shtm

Below please find information that will help you through the claim process:

To submit additional claim information:

Mail to: P. O. Box 12029 Austin, Texas 78711-2029

Fax to: (512) 224-3889

To locate a treating doctor:

www.texasmutual.com/workers/iwADL.shtm

To contact the handling adjuster:

Call: (800) 859-5995

Monday - Friday; 8:00 a.m. - 5:30 p.m.

To obtain a copy of the Employer and Employee Rights and Responsibilities in the

Workers' Compensation System:

www.texasmutual.com/employers/erRights.shtm

To locate a pharmacy, or for pharmacy questions, contact Scripnet:

Call: (888) 880-8562 www.scripnet.com To obtain a copy of the Employer and Employee Rights and Responsibilities for the workers' comp health care network:

www.texasmutual.com/hcn/hcn.shtm

Additional Texas Mutual® online services at www.texasmutual.com, available 6 a.m. - 9 p.m., include:

- o Obtain logon id, or for immediate logon id, call (800) 859-5995, M-F, 8:00 a.m. 5:30 p.m.
- o Submit first report of injury in the Employers section
- o Submit wage statement when reviewing loss runs and claim details
- o Obtain specific claim summary information



Claim Number: 99K0000575596

Notification Date: 07/06/2009

BUSINESS/EMPLOYER

EMPLOYER'S FIRST REPORT OF INJURY

INJURED EMPLOYEE Name: JOSEPH HERNANDEZ SSN: XXX-XX(b)

Mailing

Address:(b) (4)

County: Physical Address:

County: Home Phone:

Date of Birth: 00/00/0000 Marital Status: Unknown

Gender: Language: Male English Dependents: 00

MEDICAL PROVIDER

Name: JEAN T DOLAN MD

Tax ID:

Address: 15810 MIDWAY RD

ADDISON TX 75001

Phone: (800)733-7098 Fax:

ATTORNEY

Represented by Attorney:

Name: Phone:

Name: C E S ENVIRONMENTAL SERVICES I Address:

4904 GRIGGS RD

HOUSTON TX 77021-3208

Phone: (713)676-1460 **Ext:**

Fax: (713)676-1676

Policy Number:

0001086044

FEIN:

760592985

Location ID:

EMPLOYMENT

Occupatiou:

Hire Date: 00/00/0000

Partner/Officer/Owner:

Date Lost Time Began: 00/00/0000 Rcturn to Work Date:

Last Paycheck was:

07/01/2009

State: TX

Wage: Frequency:

Hours/Week:

Days/Week:

Period Start: 00/00/0000

Period End: 00/00/0000

Supervisor Name:

Phone:

Ext:

PREPARER OF REPORT

Name:

Phone: Email:

Ext:

Fax:

INJURY INFORMATION

Date of Injury: 06/26/2009

Time: 00:00

Address Where Injury Occurred:

TX

Date Reported: 00/00/0000

Nature of Injury: HEAT PROSTRATION

Cause of Injury: MISC. CAUSES-ABSORB, INGEST

OR INHALATION, NOC

MULTIPLE BODY

PARTS(INCL.BODY

SYSTEMS & BDY PARTS

Fatality:

Part of Body:

County: Witnesses:

Name:

Phone:

Name:

Phone:

Name:

Phone:

How and Why the Injury/Illness Occurred

HEAT EXHAUSTION. PER MEDNAR, THE PATIENT STATED, "I WAS OVER HEATED AND MY HEAD AND STOMACH STARTED HURTING."

CLAIM CREATED FROM DWC-69, MEDNAR.

C E S ENVIRONMENTAL SERVICES I 4904 GRIGGS RD HOUSTON TX 77021-3208

Texas Mutual Insurance Company has redesigned the First Report of Injury (eFROI) section of texasmutual.com. More than 55% of all new reports of injury are submitted through the Texas Mutual Online (TMO) application. The redesign makes the first report of injury services more intuitive and easier for policyholders to use.

Here is an overview of the new features:

- Policyholders will now have the ability to login. By logging in, policy information will pre-fill.
- Customers who login will also have the ability to create profiles with information they always want to pre-fill in a first report of injury (such as supervisor or medical provider information).
- A copy function has been added to automatically populate information that may be the same (such as preparer, contact or address information).
- Certain fields have default values. For example, the state field defaults to Texas for all address fields
- Search functions have been added to make it easier to find the part of body or nature of injury, when reporting a claim.

To use the enhanced online claim reporting tool:

- Go to texasmutual.com
- Click on Report an Injury in the Employer section
- Login with your username and password for policy information to pre-fill, or you have the option to skip login.

To see the redesign, a video is available at the login page. If you are not registered to use Texas Mutual online services, complete the online application at texasmutual.com, or call the Information Services Center at (800) 859-5995.

Texas Mutual Insurance Company P.O. Box 12029 Austin, TX 78711-2029 Phone: (800) 859-5995; Fax: (512)224-3889



07/14/2009

Texas Department of Insurance

Division of Workers' Compensation

7551 Metro Center Dr., Ste 100, MS-96, Austin, TX 78744-1609 Voice 512.804.4636 Fax 512.804.4101 www.tdi.state.tx.us

CES ENVIRONMENTAL SERVICES INC 4904 Griggs Rd Houston, TX 77021-3208 RE: Claim No.:

o.: (b) (4

JOSEPH HERNANDEZ

Injured Worker: Date of Injury:

06/26/2009

Carrier Name: Texas Mutual Insurance Co

Carrier No.: 99K0000575596

NOTICE TO EMPLOYER

The Texas Department of Insurance, Division of Workers' Compensation (DWC) has received notice of an injury/death on the above-named employee. Enclosed is information about your rights and responsibilities as an employer and information to help you develop successful return to work procedures. Services available from DWC to assist employers include:

RETURN TO WORK SERVICES: DWC provides information to help employers reduce costs and control lost time by successfully returning injured workers to productive work as soon as possible following an injury. A "Resource Guide" and other information are available on DWC website. In addition, workshops, seminars, and individual consultations also are available.

OSHCON - Free health and safety consultations are provided to small private employers on request. Emphasis is placed on assisting the employer in developing effective health and safety programs and identifying and correcting hazards in the workplace, including industrial hygiene testing.

<u>Safety Information Library</u> - Health and safety training programs are available to employers, employees, academic institutions and other entities in Texas. Additionally, the Division maintains a resource center containing health and safety information, visual aids, and publications. A large number of safety educational materials are available for download from the Division's web site. The Division staff also provide assistance with research on specific health and safety issues and questions.

<u>Safety Education & Training</u> - Onsite professional occupational safety training is available to public and private employers throughout the State of Texas. We can help any Texas business, whether or not the company subscribes to workers' compensation.

More information on these services can be located on the Division's website at www.tdi.state.tx.us.

Your workers' compensation insurance carrier is required to notify you of any claim filed against your policy. You may submit a written request to your insurance carrier to secure additional information regarding payments, reserves, and the effect on premium rates set by the Texas Department of Insurance. This information is intended to inform you of the means to secure specific information regarding your company's workers' compensation claims. Please direct your questions regarding premium rates to the Texas Department of Insurance, Workers' Compensation Division, 333 Guadalupe Street, Austin, Texas 78701 (telephone 512-322-3495).

If you prefer this information be mailed to an address other than **4904 Griggs Rd**, **Houston**, **TX 77021-3208**, please contact your workers' compensation insurance carrier, who will advise the Division of any address changes. Future mailings will be forwarded to the corrected address.

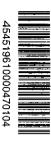
THIS NOTICE DOES NOT REQUIRE A RESPONSE.

Sincerely,

Texas Department of Insurance, Division of Workers' Compensation

Enclosure:

Rights and Responsibilities



Employer Rights and Responsibilities under the Texas Workers' Compensation Act

For further information about your rights and responsibilities, please refer to the Texas Workers' Compensation Act (Texas Labor Code, Title 5, Subtitle A) and to the administrative rules of the Texas Department of Insurance, Division of Workers' Compensation. For specific information, please write the Division at 7551 Metro Center Drive, Suite 100, Austin, TX 78744-1609, or call 1,800.252.7031 to be connected to the field office nearest you or

EMPLOYER RIGHTS

The Texas Workers' Compensation Act, Texas Labor Code, Section 409.011, provides covered employers the following rights:

- to be present at all administrative proceedings related to a claim
- To present relevant evidence related to a claim at any proceeding
- · to report suspected fraud
- to contest the compensability of an injury if the insurance carrier accepts liability for the payment of benefits.
- to receive notice, after making a written request to the insurance carrier, of
 - an administrative or a judicial proceeding related to the resolution of a claim; or
 - · a proposal to settle a claim
- to contest the failure of the insurance carrier to provide accident prevention services required by the Act.

EMPLOYER RESPONSIBILITIES

1) Reporting Injuries

Employer's First Report of Injury: You must report <u>to your insurance carrier</u> within 8 days of the date you receive notice or have knowledge of:

- a work-related injury that causes an employee to miss more than 1 day of work
- an occupational illness that you know about, even if the employee has not missed any work
- a work-related death

Do not file an employer's First Report of Injury with the Texas Department of Insurance, Division of Workers' Compensation unless specifically requested to do so.

You may report injuries by mail, fax, telephone, or electronic transmission to your insurance carrier. Failure to timely report an injury or illness may result in an administrative penalty not to exceed \$500 to be assessed by the Division. Send a copy to the injured worker and provide the employee a summary of rights and responsibilities in the wording adopted by the Division.

You must keep a record of work-related injuries, illnesses, and deaths. Keep the records for at least 5 years from the last day of the year in which the injury, illness, or death occurred, or for the period of time required by the Occupational Safety and Health Administration, whichever is greater.

2) Other Reporting Responsibilities

Employer's Wage Statement:

You must report an injured worker's wages and other compensation to your insurance carrier. Send Form-3, Employer's Wage Statement, to your insurance carrier within 30 days of the date income benefits begin to accrue. Send a copy of the form to the injured worker. Do not file the form with the Division unless specifically requested to do so.

Supplemental Report of Injury: You must report any changes in an injured worker's pay or employment status to your insurance carrier. Send Form-6, **Supplemental Report of Injury**, to your insurance carrier within:

- · 3 days of the date the injured worker returns to work;
- 3 days of the date an injury causes the employee to miss additional work after returning to work;
- 10 days of the end of a pay period in which the injured worker's weekly earnings change as a result of the injury;
- 10 days of the date the injured employee resigns or is terminated.

Send a copy of the form to the injured worker. Do not file the form with the Division unless specifically requested to do so.

If you do not timely send the required forms to the insurance carrier and the injured worker, you could be subject to a penalty of up to \$500 per occurrence for the Employer's Wage Statement and the Supplemental Report of Injury.

3) Posting and Notice Responsibilities

(This section does not apply to Political Subdivisions)

Notice of Coverage or Change in Coverage: You must post notices in your workplace telling your employees that:

- You have workers' compensation insurance and provide the name of your workers' compensation insurance carrier;
- the Division has staff to explain injured workers' rights and responsibilities and to help resolve disputes about their claims;
- the Division has a 24-hour, toll free hotline to report suspected safety violations in the workplace.

Posted notices must be in wording and format adopted by the Division. If you do not post these notice, you could be subject to a penalty up to \$500.

You must give all of your employees written notice if you cancel your workers' compensation policy within 15 days of the date you cancel your policy or are notified that your insurance carrier intends to cancel you policy. If you do not provide this notice to your employees, you could be subject to a penalty up to \$500 per occurrence.



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Employer Rights and Responsibilities under the Texas Workers' Compensation Act

Ear farther lefteredition about your rights and reapteredities, theate refer to the Tetas. Mother's Compensation Act (Taxes Leber Code, Title S. Subbite A) and to the participation rules of the Taxes Department of Assurance Disjuicit SF Markers. Compensation of Early English Information, please with the Division at 1861 Marys. Caster Divis, Title 100, Austin, IX NOVA 1800 to call 1-800-202-2021 to by connected to the fact office engages you to

Notice to new Employees: You must give each new employee at the time of hire a written notice that includes the information in the posted notices. The written notice must also tell new employees that they have the right to choose not to be covered by your workers' compensation policy. Employees have 5 days from the date they begin employment to notify you in writing if they do not want to be covered by your policy. The written notice to new employee must be in wording adopted by the Division. If you do not provide this notice to new employees, you could be subject to a penalty up to \$500 per occurrence.

For Copies of the required notices, call 512-804-4333, or write DWC Forms, MS-91, 7551 Metro Center Drive, Suite 100, Austin, TX 78744-1609.

4) Other Responsibilities

Drug Policy, if required: If you have 15 or more employees, you must have a policy to eliminate drug abuse in your workplace. You must give a copy of the policy to each employee.

For a free copy of the Division's Drug-Free Workplace Resource Guide, which includes information on development of a drug-free workplace policy, call 512-804-4624 or write DWC Health and Safety Resource Center, MS-25, 7551 Metro Center Drive, Suite 100, Austin, TX 78744-1609. The Drug-Free Workplace Resource Center Publications/Videos at our website (www.tdi.state.tx.us).

Accident Prevention Plan, if required: If you are identified by the Division as a hazardous employer or are identified by the Texas Mutual Insurance Company to participate in an injury prevention program, you must adopt an accident prevention plan developed by an approved consultant who may be from the Division or your insurance carrier, or may be a Division-approved provider. The initial consultation must occur within 30 days of the date you receive notice that you have been identified to participate in an accident prevention program.

ADMINISTRATIVE AND CRIMINAL VIOLATIONS

Fraud: You could be subject to a penalty up to \$5,000 and possibly referred for criminal fraud investigation if you knowingly or intentionally commit an act to deny workers' compensation benefits to someone legally entitled to receive benefits. You also could be liable for past payments and interest.

Charge Backs: You may not charge your workers' compensation premiums back to your employees either directly or indirectly. If you charge premiums back to employees, you could be subject to a penalty up to \$1,000 per violation. Your employees may also recover damages in court.

Misrepresentation of Payroll: You could be subject to a penalty up to \$5,000 per occurrence if you intentionally misrepresent your payroll or provide false information to obtain lower insurance premiums. You could also be held liable for missed premiums.

Discrimination Against Employees: Texas law prohibits discharging or discriminating against an employee because the employee in good faith filed a workers' compensation claim, hired an attorney, testified, or will testify in a workers' compensation proceeding.

Refurn to Work Program for Employers

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By providing meaningful, productive work for your injured workers during his or her recovery, you can reduce your workers' compensations costs significantly.

Because your experienced and trained employees are continuing to do productive work for your company, you will be paying earned wages instead of workers' compensation income benefits. Most often, being away from work is medically unnecessary and can result in additional complications to the injury, delaying recovery and increasing the negative impact of the injury on injured workers and their families.

Talk to your insurance adjuster as soon as an injured worker begins to lose time from work.

Your insurance carrier can provide return to work coordination services to help you reduce unnecessary lost time and help your employees to continue to work during their recovery. Your adjuster also can help you understand the functional capabilities of your employees and help you work with health care providers as your employees recover.

It is important to help an injured worker focus on recovery.

Returning to a normal routine, including employment, as soon as possible is an integral part of the recovery process. Studies have shown that being off work longer than absolutely necessary can cause additional physical complications that could not only delay recovery but also increase your workers' compensation costs. Additional studies have shown that injured workers who continue to work require less medical care; therefore, you not only be paying lower medical costs for these employees but also over time should have lower workers' compensation premiums.

If an injured worker is unable to perform his or her regular duties, consider allowing the employees to perform a different job, within their capabilities, that is still important to the daily operations of your organization.

Modified or alternate assignments that are transitional in nature make it possible for the injured workers to stay engaged as productive members of the workplace. Consider modifying injured workers' work hours or allowing the injured workers to work at a slower pace. By remaining active in your employee's recovery process you not only help your business but you also increase the likelihood that your employees will continue to be productive members of the workforce.

DWC provides information to help employers with successful stay at work/return to work efforts. The information is available on the DWC website at http://www.tdi.state.tx.us/ or the information can be mailed to you. To request a copy of the Employers Resource Guide, or for specific assistance or questions, please call DWC at (512) 804-4804, or e-mail rtw@.tdi.state.tx.us.

You also can contact your local DWC Field Office. It is essential that all system participants work together to help injured workers stay motivated in the recovery and return to work process.

Thank you in advance for your interest and cooperation in this process.



April 30, 2009



Claim & Information Services
P.O. Box 12029
Austin, TX 78711-2029
1-800-859-5995 (512) 224-3800
Fax (512) 224-3889

C E S ENVIRONMENTAL SERVICES 4904 GRIGGS RD HOUSTON, TX 77021-3208

Re:

Claim #: Employee: Soc. Sec.: Employer: (b) (4) BRIAN WEATHER (b) (4)

C E S ENVIRONMENTAL SERVI 04/14/2009

Date of Injury: 04/14/2009 DWC #: PENDING

In accordance with the Division of Workers' Compensation Rules, we are requesting that you submit the information indicated below. The DWC3 and DWC6 forms are available for printing from our website, www.texasmutual.com, under services, or from the division's website, www.tdi.state.tx.us. For your convenience, a DWC3 is now available for you to complete and submit on-line. It is located on our website, www.texasmutual.com under the Employers - Loss Run & Claims Detail Section. If you need assistance with filing the DWC3 on-line please contact me. If you do not have access to the Internet, we will be happy to send you a blank form.

DWC3 EMPLOYER'S WAGE STATEMENT (Rule 128.2) - Please fax or email attachment or use the on-line version (www.texasmutual.com).

OR

DWC3SD EMPLOYER'S WAGE STATEMENT FOR SCHOOL DISTRICTS (Rule 128.7)

DWC6 EMPLOYER'S SUPPLEMENTAL REPORT OF INJURY OR ILLNESS (Rule 120.3) - Please fax or email attachment. The following time frames apply.

Within 10 days after:

- The end of each pay period in which the employee's earnings have changed as a result of the injury, OR.
- The employee resigns or is terminated.

Within 3 days after:

- The employee begins to lose time from work as a result of the injury, OR
- The employee returns to work, OR
- The employee, after returning to work experiences an additional days(s) of disability as a result of the injury.

Failure to provide the required information is an administrative violation and may result in the assessment of a penalty from the Division of Workers' Compensation.

AND

EMPLOYEE ACKNOWLEDGEMENT OF WORKERS' COMPENSATION NETWORK FORM (This form(s) shall be completed, signed and submitted). Please fax or send attachment via email as soon as possible.

☐ COPY OF THE POST-ACCIDENT DRUG SCREEN RESULTS

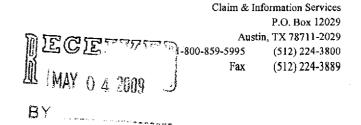
Thank you for your prompt attention to this matter. If you have any questions, please call me at 1-800-859-5995 ext. 4716.

Sincerely,

Patricia Cummings CAT WORKERS' COMP SPEC II



April 29, 2009



C E S ENVIRONMENTAL SERVICES 4904 GRIGGS RD HOUSTON, TX 77021-3208

Re:

Claim #:

Employee:

Soc. Sec.:

(b) (4)

BRIAN WEATHER

Employer:

C E S ENVIRONMENTAL SERVI

Date of Injury: 04/14/2009

Dear C E S ENVIRONMENTAL SERVICES,

I represent Texas Mutual Insurance Company for the above referenced workers' compensation claim.

I have attempted to contact your office and was unable to reach you. Please contact me at your earliest convenience to discuss this claim. I can be reached at (800) 859-5995 ext. 4716. Please disregard this notification if I have spoken with you prior to your receiving this letter.

Thank you for your kind attention to this matter.

Sincerely,

Patricia Cummings
CAT WORKERS' COMP SPEC II

Send to workers' compensation carrier:

Texas Mutual 713-316-2191

(Name and fax number of carrier)



| CLAIM# | (b) (4) |
|--------|-------------|
| CARRIE | R'S CLAIM # |

| 7 | Initial | □ Amended |
|---|---------|-----------|
| | | |

EMPLOYER'S WAGE STATEMENT

The Texas Workers' Compensation Act and Workers' Compensation rules require an employer to provide an Employer's Wage Statement to its workers' compensation insurance carrier (carrier) and the claimant or the claimant's representative, if any. The purpose of the form is to provide the employee's wage information to the carrier for calculating the employee's Average Weekly Wage (AWW) to establish benefits due to the employee or a beneficiary.

The AWW is based on the wages the employee earned in the 13 weeks immediately preceding the date of injury (or the wage a similar employee earned if the employee did not work the full 13-week period). "Wages" include all forms of remuneration payable to an employee for personal services, including fringe benefits. To simplify filing, employers may file wages in a monthly, biweekly, or weekly manner as discussed below.

NOTE - An employer who falls without good cause to timely file a complete wage statement as required by the Texas Workers' Compensation Act, Texas Labor Code, Section 408.063(c) and Worker's Compensation Rule 120.4 may be assessed an administrative penalty not to exceed \$500.00 for an initial offense and not to exceed \$10,000.00 for a repeated administrative violation.

The employer shall timely file a complete wage statement in the form and manner prescribed by the Division.

- (1) The wage statement shall be filed ("filed" means received) with the carrier, the claimant, and the claimant's representative (if any) within 30 days of the earliest of:
 - (A) the employee's eighth day of disability;
 - (B) the date the employer is notified that the employee is entitled to income benefits;
 - (C) the date of the employee's death as a result of a compensable injury.
- (2) The wage statement shall also be filed with the Division within seven days of receiving a request from the Division (Only When Requested).
- (3) A subsequent wage statement shall be filed with the carrier, employee, and the employee's representative (if any) within seven days if any information contained on the previous wage statement changes (such as if the employer discontinues providing a nonpecuniary wage that was initially continued after the date of injury).

All applicable DWC rules can be found at www.tdl.state.tx.us

| | | <u></u> | | | | | | | |
|-----------------------|-----------------------------------|---------------------------------|--------------------------------|----------------------|--|--|--|--|--|
| EMPLOYEE AN | D EMPLOYER I | NFORMATION | | | | | | | |
| Employee's Name (Las | st, First, M.J.): | | Employer's Business Name: | | | | | | |
| Weathers. Br | ian | | CES Environmental Services, In | | | | | | |
| Employee's Mailing Ad | dress (Street or P.O. F | Bpx): | Employer's Mailing Addre | | | | | | |
| (D) (4) | | ŕ | 4904 Griggs Ro | 1 | • | | | | |
| City: | State: | ZIP Code: | City: | State: | ZIP Code: | | | | |
| (b) (4) | | | Houston | TX | 77021 | | | | |
| | ⊏űasi í <mark>pur digits):</mark> | - | Federal Tax I.D. Number: | | | | | | |
| (D) (4) | | | 76-0592985 | | | | | | |
| Date of Hire: | Date | of Injury: | Name and Phone # of Per | rson Providing Wage | Information: | | | | |
| (b) (4) | 4/ | 14/09 | Prabhakar Thangudu | | | | | | |
| ☐ As of today's date | e, the employee is n | ot back at work. OR | | | | | | | |
| | | and is working: | I HEREBY CERTIFY THA | AT this wage stateme | ent is complete, accurate, and | | | | |
| without restrict | tion. OR | | | | tion Act and applicable rules, | | | | |
| . — | s and is earning wa | ges of \$ per | | | nonpecuniary wages paid for jury (as described on page 2) | | | | |
| week/month (circl | le one). | - | | | sentation about a workers' | | | | |
| | | file the Supplemental Report of | | | fines and/or imprisonment. | | | | |
| |) to report changes i | n Work Status and Post-Injury | 2 | Billy A | 5 13 W | | | | |
| Earnings. | | | Signature: | ave 1 The | Date: 5-12-09 | | | | |
| EMPLOYMENT | STATUS AT TIN | TE OF INJURY (Check A | dl That Apply) | · | | | | | |
| III Euli times ample | and the regularity was | to at D Bouttimes Beaute | Course of Conducts | [] Minor | loos than 18 years of age | | | | |

- ☑ Full-time: employee who regularly works at least 30 hours per week and whose schedule is comparable to other employees of the company and/or other employees in the same business or vicinity who are considered full-time.
- ☐ Seasonal: employee who as regular course of conduct engages in seasonal or cyclical employment that may or may not be agricultural in nature and that does not continue throughout the year.
- ☐ Part-time: Regular Course of Conduct: employee whose work history for the 12-month period preceding the injury shows the person only worked part-time during that period.
- ☐ Part-time: Not Regular Course of Conduct: employee whose work history for the 12-month period preceding the injury shows part-time and full time work during that period.
- Apprentice: employee who is learning a skilled trade or art by practical experience under the direction of a skilled crafts person or artisan.
- ☐ Minor: employee less than 18 years of age and not emancipated by marriage or judicial action who is also an apprentice, trainee or student.
- ☐ Student: employee enrolled in a course of study in high school, college or other institute of higher education or technical training.
- ☐ Trainee: employee undergoing systematic instruction and practice in some art, trade or profession with a view towards proficiency in it.

SAME OR SIMILAR EMPLOYEE?

The wage information on this form is for:

☑ The injured Employee OR ☐ A Similar Employee (NOTE – If requested by the Division, the employer shall identify the similar employee whose wages were provided.)

If the employee was not employed for 13 continuous weeks before the date of injury, report the wages of an employee who has training, experience, skills & wages comparable to the injured employee AND who performs services/tasks comparable in nature and in number of hours. If no similar employee exists, report the limited available wages earned by the injured employee prior to the injury.

NOTE TO INJURED EMPLOYEE – If you were injured on or after 7/1/02, and had employment with more than one employer on the date of injury, you can provide your insurance carrier with wage information from your other employment for the carrier to include in your AWW and this may affect your benefits. Contact your carrier for additional information or call the Division at (800) 252-7031. You can also read rule 122.5 at www.tdi.state.tx.us.



DIVISION OF WORKERS' COMPENSATION

| WAGE INFORMATION INSTRUCTIONS Em | Weathers, | Brian | Social Security # | (b) (4) | ate of Injury | 4/1 | 4/0 |)(|
|----------------------------------|-----------|-------|-------------------|---------|---------------|-----|-----|----|
|----------------------------------|-----------|-------|-------------------|---------|---------------|-----|-----|----|

- The employer shall report all wages earned in the 13 weeks immediately preceding the date of injury. If the employee is paid on a monthly or semi-monthly basis, the employer may provide wages for the 3 months preceding the date of injury. Monthly wages may also be converted to weekly wages by dividing the gross monthly amount by 4.34821. If the employee is paid on a biweekly basis, the employer may provide the wages for the 14 weeks preceding the date of injury. When setting the periods to report, the employer may adjust the reporting period backward slightly (up to six days) to line up the reporting timeframes with the employer's natural pay cycle. However, the employer shall not report wages earned on or after the date of injury.
- If reporting weekly earnings, use all 13 Period Columns below. If reporting 3 months of earnings, either convert the wages to weekly earnings or use the first 3 Period Columns. In all cases, indicate the dates that each period covers.

| PECUNIARY WAGE | INFORMA | TION | Pecuniary Wages include all wages that are paid to the employee in the form of money. These include, but are hourly, weekly, biweekly, monthly, etc. wages; salary; tips/gratuities; piecework compensation; monetary allowances; I commissions. Earnings are reported in the periods they are earned, NOT when they are paid and some (such as commissions) need to be prorated. Pecuniary wages don't include payments made by an employer to reimburse the employee's equipment or for paying helpers or to reimburse for travel expenses. Consider as earnings amountailed and any vacation, personal or sick leave an employee used but not the market value of leave time earned but not | | | | | | s; bonuses; and as bonuses and employee for the nounts from paid | | | | | |
|------------------------|---------|---------|--|---------|---------|---------|---------|---|---|----|----|----------|----|---------|
| PERIOD # (Week #, | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | |
| Month #, or Bi-Week #) | | <u></u> | | | | | ļ | | ļ | | ļ | <u> </u> | | |
| FROM DATE: | 1/01/09 | 1/16/09 | 2/01/09 | 2/16/09 | 3/01/09 | 3/16/09 | 4/01/09 | | | | | | | |
| TO DATE: | 1/15/09 | 1/31/09 | 2/15/09 | 2/28/09 | 3/15/09 | 3/31/09 | 4/15/09 | | | | | | | TOTALS |
| # HOURS WORKED: | 120 | 120 | 120 | 120 | 120 | 120 | 120 | | | | | | | 840 |
| GROSS WAGES EARNED: | (b) (4) | | | | | | | | | | | | | (b) (4) |

Nonpecuniary Wages include all wages paid to the employee in a form other than money. These include, but are not limited to, the

| Nonpecuniary Wage Type | Employer Provided Prior To Injury? | | Specify Value Or Amount Earned in Each Reported Period For Each Benefit Provided Prior To Injury (Use the same periods as used above) | | | | | | | | | | Will Employer Continue To Provide? | | Date Benefit Suspended (if suspended) | | | |
|---------------------------|--|----|--|---|---|---|---|---|---|---|--------------|----|--|----|---|-----|----|---|
| | YES | NO | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | YES | NO | |
| Health Insurance | | | _ | | | | | | | | | | | | | | | |
| Laundry/ Cleaning | | | | | | | | | | | | | | | | | | |
| Clothing/ Uniforms | | | | | | : | | | - | | | | | | | | | |
| Lodging/ Housing/ | - | | | | | | | | | | | | | | | | | |
| Food/ Meals | | | | | | | | | - | | : | | | | | | | |
| Vehicle/ Fuel | | | <u> </u> | 1 | | | | | | | | | - | | | | - | - |
| Other | | | | | | | i | | | | | | | | | | | |



NONDECHNIADY WARE INFORMATION



4904 Griggs Road Houston, TX 77021 Phone: (713) 676-1460 Fax: (713) 676-1676

Fax

Claimet

| Phone | | Date: | |
|-------|--------------|--------|--|
| Fax: | 512-224-3889 | Pages: | |
| То: | Tx Mutual | From: | Prabhakar R. Thangudu Mobile: (281) 433-9792 Email: pthangudu@cesenvironmental.com |
| | | | |

****** Date MAY-12-2009 ***** Time 12:40 *******

Date/Time = MAY-12-2009 12:37

Journal No. = 080

Comm. Result = OK

Page(s)

= 006

Duration = 00:02:46

File No. = 142

Mode

= Memory Transmission

Destination = 15122243889

Received ID =

Resolution = Fine

-CES ENVIROMENTAL -

***** DP-C264 **************

_ **** <u>_</u>

7137488664- *******



Claim and Insurance Services P.O. Box 12029 Austin, Texas 78711-2029

NOTICE OF DENIAL OF COMPENSABILITY/LIABILITY AND REFUSAL TO PAY BENEFITS

DATE: 05/11/2009

WEATHER, BRIAN TO:

7803 12TH FAIRWAY LANE

HUMBLE TX 77346

RE: Date of Injury:

Nature of Injury:

Part of Body Injured: Employee SSN:

DWC #:

Carrier Name:

Carrier Claim Number:

Employer:

Texas Mutual Insurance Company

04/14/2009

C E S ENVIRONMENTAL SERVI

4904 GRIGGS RD

HOUSTON TX 77021-3208

NO PHYSICAL INJURY

NO PHYSICAL INJURY

On 04/27/2009 we received notice that you reported an on the job injury. We are denying your claim for workers' compensation benefits. Workers compensation benefits, including medical benefits, are not being paid because:

Texas Mutual Insurance Company denies this claim in its entirety. Carrier does not dispute that Mr. Weather was present at the time of the death of a fellow employee. However, the Carrier disputes that Mr. Weather sustained an injury in the course and scope of employment, either as a physical injury or mental trauma. Further, the fellow employee appears to have died from a heart attack and not from any traumatic injury.

If you do not agree with the denial and refusal to pay benefits, please contact me:

PATRICIA CUMMINGS

Adjuster's Name: Toll Free Telephone #: Fax #/E-mail Address: (800) 859-5995 (512) 224-3889

If we are unable to resolve the issue to your satisfaction, you may contact the Texas Department of Insurance, Division of Workers' Compensation for further assistance. You have the right to request a Benefit Review Conference. You can contact the Division office handling your claim at 1-800-252-7031.

If you would like to receive notices such as this by facsimile or e-mail, please contact me and provide your facsimile number or e-mail address.

Please note that making a false or fraudulent workers' compensation claim is a crime that may result in fines and/or imprisonment.

CC TDI/DWC MAIL DELIVERY WEATHER, BRIAN

C E S ENVÍRONMENTAL SERVI



C E S ENVIRONMENTAL SERVICES I 4904 GRIGGS RD HOUSTON TX 77021-3208

Texas Mutual Insurance Company has redesigned the First Report of Injury (eFROI) section of texasmutual.com. More than 55% of all new reports of injury are submitted through the Texas Mutual Online (TMO) application. The redesign makes the first report of injury services more intuitive and easier for policyholders to use.

Here is an overview of the new features:

- Policyholders will now have the ability to login. By logging in, policy information will pre-fill.
- Customers who login will also have the ability to create profiles with information they always want to pre-fill in a first report of injury (such as supervisor or medical provider information).
- A copy function has been added to automatically populate information that may be the same (such as preparer, contact or address information).
- Certain fields have default values. For example, the state field defaults to Texas for all address fields.
- Search functions have been added to make it easier to find the part of body or nature of injury, when reporting a claim.

To use the enhanced online claim reporting tool:

- Go to texasmutual.com
- Click on Report an Injury in the Employer section
- Login with your username and password for policy information to pre-fill, or you have the option to skip login.

To see the redesign, a video is available at the login page. If you are not registered to use Texas Mutual online services, complete the online application at texasmutual.com, or call the Information Services Center at (800) 859-5995.

Texas Mutual Insurance Company P.O. Box 12029 Austin, TX 78711-2029 Phone: (800) 859-5995; Fax: (512)224-3889



04/28/2009

C E S ENVIRONMENTAL SERVICES I 4904 GRIGGS RD HOUSTON TX 77021-3208

Notification Confirming Receipt of Claim

Date of Injury: Injured Worker:

Claim Number; Policy Number: 04/14/2009

WEATHER, BRIAN

0001086044

Attached is a copy of the information you reported to Texas Mutual Insurance Company which was used to establish this claim. You may submit additional claim information to Texas Mutual Insurance Company. If you have questions regarding this report of injury please contact us at (800) 859-5995.

If your policy includes our workers' compensation health care network option you are required by law to obtain a second Employee Acknowledgement of Workers' Compensation Network Form signed by the injured worker. Please submit a copy of the signed, second acknowledgement form to Texas Mutual Insurance Company. You can find a copy of the form online at www.texasmutual.com/hcn/shtm

Below please find information that will help you through the claim process:

To submit additional claim information:

Mail to: P. O. Box 12029 Austin, Texas 78711-2029 Fax to: (512) 224-3889

To locate a treating doctor:

www.texasmutual.com/workers/iwADL.shtm

To contact the handling adjuster:

Call: (800) 859-5995

Monday - Friday; 8:00 a.m. - 5:30 p.m.

To obtain a copy of the Employer and Employee Rights and Responsibilities in the

Workers' Compensation System:

www.texasmutual.com/employers/erRights.shtm

To locate a pharmacy, or for pharmacy questions, contact Scripnet:

Call: (888) 880-8562 www.scripnet.com To obtain a copy of the Employer and Employee Rights and Responsibilities for the workers' comp health care network:

www.texasmutual.com/hcn/hcn.shtm

Additional Texas Mutual® online services at www.texasmutual.com, available 6 a.m. - 9 p.m., include:

- o Obtain logon id, or for immediate logon id, call (800) 859-5995, M-F, 8:00 a.m. 5:30 p.m.
- o Submit first report of injury in the Employers section
- o Submit wage statement when reviewing loss runs and claim details
- o Obtain specific claim summary information



Claim Number:

99K000056689203

Fax: (713)676-1676

Notification Date: 04/27/2009

EMPLOYER'S FIRST REPORT OF INJURY

INJURED EMPLOYEE

Name: SSN:

BRIAN WEATHER XXX-XX-(b)

Mailing

Address: TX

County:

Physical Address:

County:

Home Phone:

Date of Birth: 00/00/0000 Marital Status: Married

Gender:

Male

Dependents: 03

Language: English

MEDICAL PROVIDER

Name:

Tax ID:

Address:

Phone:

Fax:

ATTORNEY

Represented by Attorney:

Name:

Phone:

Part of Body:

Fatality:

BUSINESS/EMPLOYER

Name: CES ENVIRONMENTAL SERVICES I

Address:

4904 GRIGGS RD

HOUSTON TX 77021-3208

Phone: (713)676-1460 Ext:

Policy Number:

0001086044 760592985

FEIN:

Location ID:

EMPLOYMENT

Occupation: Hire Date:

Partner/Officer/Owner: Date Lost Time Began:

No 00/00/0000 00/00/0000

State: TX

Return to Work Date: Last Paycheek was:

Wage: Frequeucy:

Hours/Week:

Days/Week:

Period Start: 00/00/0000

Period End: 00/00/0000

Supervisor

Name: RYAN THOMAS

Phone:

Ext:

PREPARER OF REPORT

Name: PRABHAKAR R THANGUDU

Phone: (713)676-1460 **Ext:**

Fax: (713)676-1676

Email:

INJURY INFORMATION

Time: 00:00 **Date of Injury:** 04/14/2009

Date Reported: 04/27/2009

Nature of Injury: ALL OTHER

Cause of Injury: MISC. CAUSES-OTHER

MISCELLANEOUS, NOC

INSUFFICIENT INFO TO PROPERLY

IDENTIFY-UNCLASSED

Address Where Injury Occurred: 2420 SOUTH GULFWAY DRIVE

PORT ARTHUR TX 77640

County: Witnesses:

Name: GLEN OLSON

Phone:

Name:

Phone:

Name:

Phone:

How and Why the Injury/Illness Occurred

GRIEF. KNEW A COWORKER THAT COLLAPSED PER DWC-1.

| • | Companion C | claim to. (b) (4) |
|--|---|--|
| Send the specified copies to your Workers' Compensation Insurance Cand the injured employee. *Employers - Do not send this form: | | TWCC CLAIM# |
| Texas Workers' Compensation Com unless the Commission specifically a direct filing. | | CARRIER'S CLAIM# |
| A Mars (Last City Add) | | EPORT OF INJURY OR ILLNESS |
| Weathers, Brian | 2. Sex | 15. Date of Injury 16. Time of Injury 17. Date Lost Time 4 - 14 708 am pm |
| Social Security No. 4. Home Phone | 5. Date of Birth | 18. Nature of Injury* 19. Part of Body Injured or Exposed* Grief MA |
| 6. Does the Employee Speak English? If I | No, Specify Language | 20. How and Why injury/liness Occurred. Knew a Coworder that Collapsed |
| 7. Race 8. Ethnicity | | 23. Address Where Injury or Exposure Occurred |
| CLUNCASSIAVI | N/A | Name of business if incident occurred on a business site 2420 504th Guffwy Dwe |
| 9. Mailing Address Street or P.O. Box City State | Zip County | Port Authur TX 77640 24. Cause of Injury(fall, tool, machine, etc.)* |
| 10. Marital Status: Married | | Genef Counseling |
| 11. Number of Dependent Children | Jamie | 25. List Witnesses: Olson |
| 13. Doctor's Name: NA 14. Doctor's Mailing Address (Street or P.O.E | Box) | 26. Return to work Date/or expected die? 28. Supervisor's name Reported Reported Ry an Amage Thomas |
| | | [|
| 30. Date of Hire (b) (4) Texas? 34. Employee Payrol Classification Code | ee hired op Ecruited in Yes No | 32. Length of Service in Occupation Source Position (mm/yy) (mm/yy) (b) (4) (mm/yy) 33. Coccupation of Injured Worker |
| 36. Rate of Pay at this job 37. Full Work W Hourly Weekly Hours | eek is: 38. Last Paycheck Days Hours | (was: 39, is employee an Owner, Partner, or Corporate Officer? |
| SALARM SALARM 40 Name and Title of Person Completing For | BIWEEKEY | Yes No 41. Name of Business |
| 42. Business Mailing Address and Telephone | HSE Manager | Port Arthur Chemical & Environmental Servers, L 43. Business Location (If different from mailing address) 2420 South Surfucy Druce |
| 4904 Griggs Road City Houston State TX | Tel No:713-676-146 | City & Arthur State TX Zip 77640 |
| 44 Federal Tax Identification Number 263588960 | 45. Primary Standard Indus (SIC) Code* (4 digit) | 219 (4 digit) 2819 payer No.12635889604 |
| 48. vvorkers Compensation insurance Comp. | | 49. Policy Number 73F 000 108 6044 |
| 50. Did you request accident prevention serving Yes No If yes, did you 51. Signature and Title (READ INSTRUCTION | receive them? Yes | □ No |
| x habburetay | <u>d</u> | Date 4-27-09 |
| | procedures set forth in U | UTA) collects concerning you. You may review and have UTA JT System BPM #32. The law is found in sections 552.021, 552 |

Continued on next page

CES Environmental Services, Inc.

4904 Griggs Road Houston, TX 77021 Phone: (713) 676-1460

Fax: (713) 676-1676

Fax

| To: | From: | Prabhakar R. Thangudu |
|--|---------|---------------------------------------|
| Patrica Cummings | | Email: pthangudu@cesenvironmental.com |
| Fax: 512-224-3889 | Pages: | 2 |
| Phone: 1-800-859-5995 x 471 | 6 Date: | 4-27-09 |
| Ms. Cummings: Companion cla I will appre | | (b) (4) one hepwith this claim. |
| | | Thanks, Rabum |

******* -IND. XMT Journal- ********** Date APR-27-2009 **** Time 15:19 *******

Date/Time

= APR-27-2009 15:18

Journal No. = 075

Comm. Result = OK

Page(s)

= 002

Duration

= 00:00:30

File No.

= 951

Mode

= Memory Transmission

Destination = 15122243889

Received ID =

Resolution = Fine

-CES ENVIROMENTAL -

***** DP-C264 ****************************

_ ***** --

7137488664- *******

Brent Sittig- Reports from convolvers

BREAT OPENED my door, HE LOOKED PAIR + SICK. I WAS on the Phone. He shut my door And SA+ down IN the Chair Outside my office. I heard Bront MOAN And the Chair Hit my The side Building . I Rans outside And Found Brent on the Ground Bleeding From his woise and mouth. Breat was was wor Breathing and their was LURINE on the ground. Suze, Dening, mike Denise And Ryan. Come over to his sida We gave Brent Air From BOTTLES till they RAN out and EAUS him CPR, BRENT had No Pluser. the Ambulant ARRIVED 11 minutes Inster and STARTED WORKing on Brent. The Cop Askod me if Anyone HURT BRENT And I SAID

I, Dennis Shaddox, At approximately 1:17 pm, I was on my way to break room to change clothes to go to lunch. When Suzi said "look Brent is on the floor he just fell out of the chair," it appeared to me that he might have had a heart attack. I then checked for a pulse, noticed he was bleeding from his mouth, and he still had a weak but rapid pulse. I immediately called 911. He wasn't breathing on his own, checked for a pulse about a minute later and didn't find one, I then began administering CPR with Brian.

It took 11 minutes for EMS to arrive and he had a weak pulse when Ems took over, but was still not breathing on his own.

Dennis Shaddox

To Whom It May Concern:

I was at my desk when I received a call asking for help. When I got to the mech. office I noticed Brent lying on the ground. I, along with Dennis and Brian began CPR until the ambulance arrived.

Bo Cumberland.

On April 14' 2009, I Anthony Savoy was in the lab doing lab work. At approximately 1:00pm Suzi Mock came in and screamed Brent fell out of the chair. We all cleared the lab to see what was going on, several workers were performing CPR. I walked away from area because the scene over whelmed me.

I came back to the area after EMS arrived which was approximately 15 minutes later.

Anthony Savoy

On April 14th, 2009 at approximately 1:00 pm, I Suzi Mock exited the lab to go smoke a cigarette. Our designated smoking area is located behind the Fleet maintenance shop. As I turned the corner walking towards the shop, I noticed Brent sitting in a chair outside the shop talking on his cell phone. I took a few more steps and he fell out of the chair face first. I then ran back to the lab and screamed at Ryan Thomas to call 911 that Brent was down. We took off running back to the where Brent was lying on the ground. Dennis called 911 and by that time everyone was around trying to assist. They started doing CPR, 11 or 12 minutes had passed before EMS arrived and took over.

Suzi Mock

Suz mock

Michael Rudd Me cody and Brent were Standing by truck while Cody Jun/odded brents truck When it was done cody the truck DACK JUP up I walked into the And Brent walked to the mechanic shop to get nil T was in the bathroom And, Brent called me to Ask About my chest PAINS he told me he was having DAINS in his, Chest people to yelling in the packaround to part pan ont then sound the corner the in Front oh mech e ground with a Delinis working Then sat

About 10 minutes

the curb Fill the Ambulance

CAME.

of my

mike

BREAT OPENED my door, HE LOOKED PAIR & SICK. I WAS on the Phone. He shut my door And Sot down IN the Charie Outside my office. I heard Brent MOAN And the Chair Hit my The side Building. I Rans outside and Found Brent on the Ground Bleeding From his noise and mouth. BRENT was not Breathing and Their Whine on the ground. Suze, Bering, Denise And Ryan. Come over to his side We gave BREAT Air From BOTHES till they RAM out And EAUE him CPR. BRENT had No Pluser. the Ambulant ARRIVEL II minutes hoster and started working on BRENT. THE COD ASKED ME if Anyone HURT BRENT And I SAID NO.

Steal GLEN OLSON I, Dennis Shaddox, At approximately 1:17 pm, I was on my way to break room to change clothes to go to lunch. When Suzi said "look Brent is on the floor he just fell out of the chair," it appeared to me that he might have had a heart attack. I then checked for a pulse, noticed he was bleeding from his mouth, and he still had a weak but rapid pulse. I immediately called 911. He wasn't breathing on his own, checked for a pulse about a minute later and didn't find one, I then began administering CPR with Brian.

It took 11 minutes for EMS to arrive and he had a weak pulse when Ems took over, but was still not breathing on his own.

Dennis Shaddox

I, Ricky Gall was at the far end of the processing unit, bringing the air generator to get fuel, I noticed everyone was gathered around the mechanics shop at approximately 1:20 pm. I noticed a person on the floor, I then went over and asked if I could assist, Ryan asked me to call 911, at this time we noticed the ambulance. I got on the 4-wheeler, rode to the front, the gate guard captain directed them to follow me to the incident site where paramedics took over.

Richal Stall

Ricky Gall

7/13/09 Road hazard

EPAHO042001892



AIG Domestic Claims, Inc. Property/Casualty Division

P.O. Box 25588 Shawnee Mission, KS 66225 (800) 242-2987 (all other) Fax (866) 723-0109 (new losses) Fax (866) 854-4926

AUTOMOBILE LIABILITY NOTICE ONLY CLAIM ACKNOWLEDGEMENT

July 22, 2009

CES ENVIRONMENTAL 4904 GRIGGS RD HOUSTON, TX 77021-3208 Attn: GREG BOWMAN

RE:

Insured

: CES ENVIRONMENTAL SERVICES INC

Carrier

: Commerce & Industry

Date of Loss Claim Number 07/13/2000

Date Reported

: 07/13/2009

Date Received

: 07/13/2009

This letter will confirm receipt of the above captioned matter which was evaluated and determined to be a Notice Only. Please be advised that we have established a claim number, but the file has not been set up for handling. Should you be informed that the status of this matter has changed and that it has become necessary for us to open an active file, please notify us at once.

ADDITIONAL CLAIM INFORMATION:

Policy Number

005062132

Loss Location

: I-45 NORTH AT 610 LOOP HOUSTON,TX

Description of Loss

OV DRIVER CLAIMS HER WINDSHIELD WAS CRACKED BY ROCK FROM IV.

IV CLAIMS THIS IS ROAD HAZARD.

Insured Driver

: UNKNKOWN UNKNOWN

RISK ANALYSIS INFORMATION:

| 1110 A 11 11 11 A 11 A 11 A 11 A 11 A 1 | 12 0 2 22 22 2 2 2 2 1 1 | | | |
|---|--------------------------|--|----------|------------------|
| Level I: | | | | - |
| Level 2: | | | ' | |
| Level 3: | | | | |
| Level 4: | | | | |
| Level 5: Level 6: | | | | |
| Level 6: | | | <u> </u> | |

Symbol Claimant CARLA JACKSON **MJC** Indemnity

007

Medical

Legal

If you have any comments or questions, please feel free to contact me. Kindly refer to the above claim number on any correspondence.

Sincerely, JODI PELLICCIA FAST TRACK 251-PC OVERLAND PARK, KS (913) 338-9254 JODI.PELLICCIA@AIUHOLDINGS.COM Original

AIG Domestic Claims, Inc. Property/Casualty Division

Shawnee Mission, KS 66225

(800) 242-2987

(all other) Fax (866) 723-0109 (new losses) Fax (866) 854-4926

AUTOMOBILE LIABILITY NEW CLAIM ACKNOWLEDGEMENT

July 17, 2009

CES ENVIRONMENTAL 4904 GRIGGS RD HOUSTON, TX 77021-3208 Attn: GREG BOWMAN

RE:

Insured

: CES ENVIRONMENTAL SERVICES INC

Carrier

: Commerce & Industry

Date of Loss

: 07/13/2009

Date Reported

: 07/13/2009

Claim Number

684-284239

Date Received

: 07/13/2009

This letter will confirm receipt of the above referenced claim.

ADDITIONAL CLAIM INFORMATION:

Policy Number

: 005062132

Loss Location

: I-45 NORTH AT 610 LOOP HOUSTON, TX

Description of Loss

: OV DRIVER CLAIMS HER WINDSHIELD WAS CRACKED BY ROCK FROM IV.

IV CLAIMS THIS IS ROAD HAZARD.

Insured Driver

: UNKNKOWN UNKNOWN

RISK ANALYSIS INFORMATION:

| | , | | | |
|----------------------|-------|------|-------|--|
| Level 1: | | | | |
| Level 2: | | | | |
| Level 3: | | | - | |
| Level 4: | | | | |
| Level 5: Level 6: | | | | |
| Level 6: | | | | |

CLAIMANT INFORMATION:

Symbol Name

CARLA JACKSON

MJC 007

If you have any comments or questions, please feel free to contact me. Kindly refer to the above claim number on any correspondence.

Sincerely, JODI PELLICCIA FAST TRACK 251-PC OVERLAND PARK, KS (913) 338-9254 JODI.PELLICCIA@AIUHOLDINGS.COM Original

Chemical Carriers LLC 6-25-09



AIG Domestic Claims, Inc. Property/Casualty Division

P.O. Box 25588 Shawnee Mission, KS 66225 (800) 242-2987 (all other) Fax (866) 723-0109 (new losses) Fax (866) 854-4926

GENERAL LIABILITY NEW CLAIM ACKNOWLEDGEMENT

July 2, 2009

CES ENVIRONMENTAL 4904 GRIGGS RD HOUSTON, TX 77021-3208 Attn: GREG BOWMAN

RE:

Insured

: CES ENVIRONMENTAL SERVICES, IN

Carrier

: AI Surplus Lines

Date of Loss Claim Number 06/25/2000

Date Reported Date Received : 06/30/2009

: 06/30/2009

This letter will confirm receipt of the above referenced claim.

ADDITIONAL CLAIM INFORMATION:

Policy Number

015022366

Loss Location

: 4904 GRIGGS ROAD HOUSTON, TX

Description of Loss

CLMT ALLEGES INSD DAMAGED LINING ON THEINSIDE OF CLMT CARGO

/ INSD FILLED TANK W/ CHEMICAL

RISK ANALYSIS INFORMATION:

| TATOLE IN LIEUT ON 1 | IX CHANGE AND THE | | | | |
|----------------------|-------------------|------|------|---|--|
| Level 1: | | | | | |
| Level 2: | | | | _ | |
| Level 3: | | | | | |
| Level 4: | | | | | |
| Level 5: | | | | | |
| Level 6: | | | | | |

CLAIMANT INFORMATION:

Symbol Name

CHEM CARRIERS LLC

MJC

013

If you have any comments or questions, please feel free to contact me. Kindly refer to the above claim number on any correspondence.

Sincerely, **RODGER MOSIMAN** FAST TRACK REP 251-PC OVERLAND PARK, KS (913) 338-9301 RODGER.MOSIMAN@AIUHOLDINGS.COM Original

Donald Bozman CBigler 6-23-09

EPAHO042001897



AIG Domestic Claims, Inc. Property/Casualty Division

P.O. Box 25588 Shawnee Mission, KS 66225 (800) 242-2987 (all other) Fax (866) 723-0109 (new losses) Fax (866) 854-4926

AUTOMOBILE LIABILITY NEW CLAIM ACKNOWLEDGEMENT

June 29, 2009

CES ENVIRONMENTAL 4904 GRIGGS RD HOUSTON, TX 77021-3208 Attn: GREG BOWMAN

RE:

Insured

: CES ENVIRONMENTAL SERVICES INC

Carrier

: Commerce & Industry

Date of Loss

06/23/2009

Date Reported

: 06/25/2009

Claim Number

Date Received

: 06/25/2009

This letter will confirm receipt of the above referenced claim.

ADDITIONAL CLAIM INFORMATION:

Policy Number

: 005062132

Loss Location

: BIGLER LP-PLANT FACILITY PASADENA,TX

Description of Loss

: I/V AT CLMT FACILITY AND MADE A TURN ANDCLIPPED THE REAR OF PARKED

O/V

Insured Driver

BOZEMAN DONALD

RISK ANALYSIS INFORMATION:

| Level 1: | | | | |
|----------|-------|------|--|-------|
| Level 2: | | | | |
| Level 3: | | | | |
| Level 4: | | | | |
| Level 5: | | | | |
| Level 6: | , | ,,,, | | · |

CLAIMANT INFORMATION:

Symbol Name

INSTRUMENTATION & ELECTRICAL S

MJC 007

If you have any comments or questions, please feel free to contact me. Kindly refer to the above claim number on any correspondence.

Sincerely,

RODGER MOSIMAN FAST TRACK REP

251-PC OVERLAND PARK, KS

(913) 338-9301

RODGER.MOSIMAN@AIUHOLDINGS.COM

Original

Plan update on this



AIG Domestic Claims, Inc. Property/Casualty Division

P.O. Box 25588 Shawnee Mission, KS 66225 (800) 242-2987 (all other) Fax (866) 723-0109 (new losses) Fax (866) 854-4926

AUTOMOBILE LIABILITY CLOSED CLAIM NOTICE

July 23, 2009

CES ENVIRONMENTAL 4904 GRIGGS RD HOUSTON, TX 77021-3208 Attn: GREG BOWMAN

RE:

Insured

: CES ENVIRONMENTAL SERVICES INC

Carrier

: Commerce & Industry

Date of Loss Claim Number : 06/23/2009 (b) (4) Date Reported

: 06/25/2009

Date Received

Indemnity

\$1,437.86

: 06/25/2009

The above captioned claim has been closed. The following amounts were paid on the claim:

Symbol Claimant

MJC

Medical

Legal

001 INSTRUMENTATION & ELECTRICAL S

007

rega

ADDITIONAL CLAIM INFORMATION:

Policy Number

005062132

Loss Location

: BIGLER LP-PLANT FACILITY PASADENA, TX

Description of Loss

: I/V AT CLMT FACILITY AND MADE A TURN ANDCLIPPED THE REAR OF PARKED

O/V

Insured Driver

: BOZEMAN DONALD

RISK ANALYSIS INFORMATION:

| THE VALUE OF THE PART OF THE PARTY OF THE PA | CIT OTTIMATE TOTAL | | | |
|--|--------------------|------|------|--|
| Level 1: | | | | |
| Level 2: | | | | |
| Level 2: Level 3: | | | | |
| Level 4: | | | | |
| Level 5: | | | | |
| Level 6: | | | | |

Thank you for allowing us to serve you on this claim. Please contact me if you have any questions or comments.

Sincerely,
RODGER MOSIMAN
FAST TRACK REP
251-PC OVERLAND PARK, KS
(913) 338-9301
RODGER.MOSIMAN@AIUHOLDINGS.COM
Original

Breent Sitting -OSHA
Inspection # 311962484

Prabhaker Thangudu

From: Anissa Wright

Sent: Wednesday, April 15, 2009 11:37 AM

To: Prabhaker Thangudu

Subject: OSHA

I reported additional details to JoAnn Figueroa of OSHA. She will email over to me our inspection number.

Thanks

Anissa Wright Human Resource CES Environmental 713-676-1460

Prabhaker Thangudu

From: Anissa Wright

Sent: Wednesday, April 15, 2009 3:02 PM

To: Prabhaker Thangudu

Subject: FW: Port Arthur CES Inspection number

From: Figueroa, Joann - OSHA [mailto:Figueroa.Joann@dol.gov]

Sent: Wednesday, April 15, 2009 1:50 PM

To: Anissa Wright

Subject: Port Arthur CES Inspection number

The inspection number assigned to the most recent Port Arthur facility fatality is: OSHA Inspection #311962484.

Joann J. Figueroa Assistant Area Director 17625 El Camino Real, Suite 400 Houston, TX 77058 281-286-0583 x223, Fax 281-286-6352

OSHA's Mission: To assure safe and healthful working conditions for working men and women.

HSAO's VISION: Utilizing the talents and skills of OSHA's finest, we will execute "The Missions" professionally, effectively, efficiently and with respect toward one another and our constituents. To meet this vision we will use the values set forth in TEAM CORE.

NOTICE:

This e-mail message and any attachments to it may contain confidential information. The information contained in this transmission is intended solely for the use of the individual(s) or entities to which the e-mail is addressed. If you are not the intended recipient, or an employee or agent responsible for delivering this message to the intended recipient, you are hereby notified that you are prohibited from reviewing, retransmitting, converting to hard copy, copying, disseminating, or otherwise using in any manner this e-mail or any attachments to it. If you have received this message in error, please notify the sender by replying to this message and delete it from your computer.

2

Leo Longonia - Accident

EPAHO042001903

713-675-973-7947



Employer's Authorization for Examination or Treatment

| Centers | |
|--|--|
| (MUST PRESENT PHOTO ID AT | r TIME OF SERVICE) (b) (4) |
| Patient Name: Leopoldo Longvia | SSN: |
| Company Name: CES ENVision ment & Services | Jnc. Date of Birth: |
| | Joston, TX7702 Date of Injury: N/3 |
| Temporary Staffing Agency: A | , |
| WORK-RELATED INJURY ILLNESS | DOT PHYSICAL |
| Post-Accident Substance Abuse Testing: | Preplacement |
| Drug Screen | Recertification |
| Breath Alcohol | Exit |
| Drug Screen and Breath Alcohol | Audiogram |
| Urine Collection Only | Regulated Drug Screen |
| | Urine Collection Only |
| DOT Regulated | Breath Alcohol |
| Non-regulated | |
| PRE-PLACEMENT EVALUATION | SUBSTANCE ABUSE TESTING |
| Job Title: TSL | Regulated |
| Physical Exam | Non-regulated |
| HPE | Urine Collection Only |
| Regulated Drug Screen | Rapid Test |
| Non-regulated Drug Screen | Pre-placement |
| Urine Collection Only | Reasonable Suspicion |
| Hair Collection | Random |
| Audiogram | Periodic |
| | Post-accident |
| | Follow-up |
| SPECIAL PHYSICAL EXAMINATIONS | Breath Alcohol |
| Asbestos | |
| Respirator | BILLING |
| Hazmat | Employee to pay charges at time of service |
| Baseline | Workers' Compensation |
| Other | Insurance Co: |
| | Policy #: |
| | Phone #: |
| Authorized By: Pohme Though | Title: HSE Manager |
| Phone: 713-676-1460 | Date: 3-24-09 |
| | |
| (copies of this form available at www | v.concentrahealth.com) |

******* -IND. XMT JOURNAL- ********* DATE MAR-24-2009 ***** TIME 14:44 *******

DATE/TIME = MAR-24-2009 14:41

JOURNAL No. = 167

COMM. RESULT = OK

PAGE(S)

= 001/001

DURATION

= 00:00:19

FILE No. = 311

MODE

= MEMORY TRANSMISSION

DESTINATION = 7139737947

RECEIVED ID = / +7139737947

RESOLUTION = STD

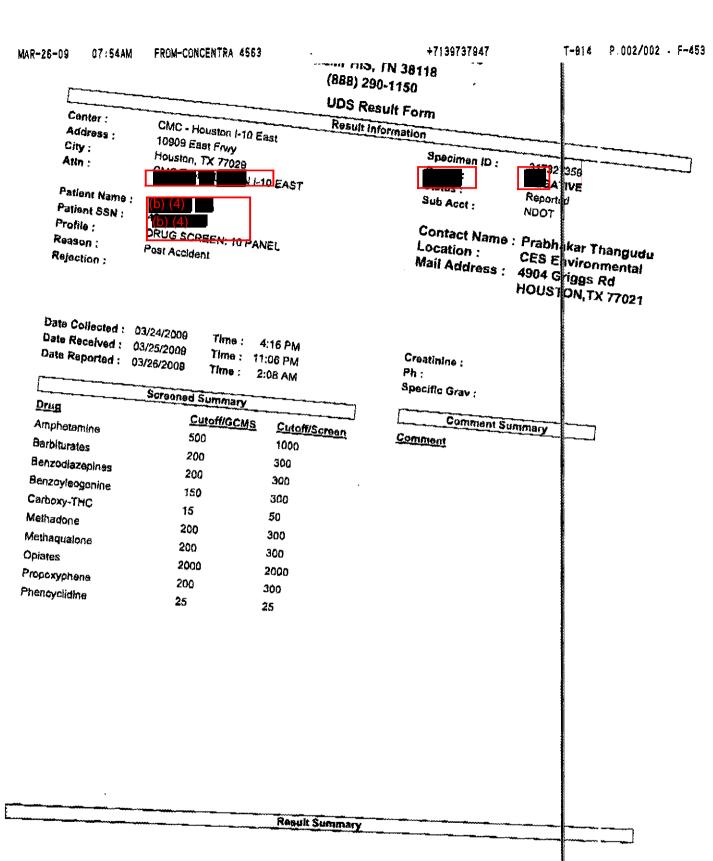
-CES Environmental Service-

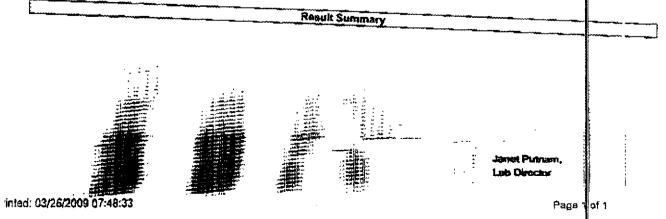
***** DP-3010 *************

- **** -

713 676 1676- ******

| | · · · · · · · · · · · · · · · · · · · | | | _ |
|------------------------------------|--|----------------------|-------------------------------|--------------------------|
| 14500 | | imp | proving America's health, c | ne patient at a time. |
| Houston Phone 7 Fax: 713 | ast Freeway 1, TX 77029 113-973-7943 3-973-7947 | | | |
| www.cc | oncentra.com | | | |
| FA | ΛX | | | |
| To: | Prabhakar Thangudu | From: | Patricia Sanchez, R | .1 |
| Fax: | 713-676-1676 | Pages: | 2 with cover | |
| Phone; | | Date: | March 26, 2009 | |
| Re: | Drug Screen Result | ce: | | |
| Commer | nfs; | | | |
| | | | | |
| As per au | ur phone conversation, Call if | you have any qu | estions. | 1 |
| | | | | į į |
| Post Acc | cident Drug Screen L. Longoria | CCF# 3173273 | 59 | |
| • | | | | 1 |
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| nis fax cove | er sheet or content may contain | oromotional inform | ation about products or sec | niles offered by |
| | If you would like to alsconlinue r | | | |
| agett eigm | • | | | |
| frite vour c | omplete fax number here: | | | |
| 1Check m | ark here to confirm your request | hat the fax numbe | r above not be used to ser | id promoilonal |
| nessages tr | om Cancentra. This will discontin | ue only those faxes | or cover sheets that conta | ain a promotional |
| nėssagė. C avs. is unla | Concentra, in accordance with the | ie I-CC, recognizes | that failure to comply with | your request, within 30 |
| | | | | |
| | ompleted information via: | | | |
| | | | | |
| | | | | |
| | | CONFIDENTIALITY N | OTICE**** | |
| OTICE: This | communication is confidential a | ind is intended only | for the person named abo | ove. No one other tha |
| ie named i | recipient is authorized to use the | information contain | ned herein in any manner. | If you have received |
| is commun | nication in error, please call the se | ender (collect if ne | cessary) to identify the erro | r. III you nave received |





Durins Accident A16 Claim
12-26-2008

EPAHO042001908



AIG Domestic Claims, Inc. Property/Casualty Division

P.O. Box 25588 Shawnee Mission, KS 66225 (800) 242-2987 (all other) Fax (866) 723-0109 (new losses) Fax (866) 854-4926

AUTOMOBILE LIABILITY **CLOSED CLAIM NOTICE**

February 9, 2009

CES ENVIRONMENTAL SERVICES INC 4904 GRIGGS RD HOUSTON, TX 77021



RE:

Insured

: CES ENVIRONMENTAL SERVICES INC

Carrier

: Commerce & Industry

Date of Loss

: 12/26/2008

Date Reported

: 12/26/2008

Claim Number

Date Received

: 12/26/2008

The above captioned claim has been closed. The following amounts were paid on the claim:

Symbol Claimant

MJC

Indemnity

Legal

001 002

MURTAZA ZOHAR **QAID ZOHAR**

006 007 \$495.00 Medical

003

CES ENVIRONMENTAL SERVICE

009

ADDITIONAL CLAIM INFORMATION:

Policy Number

: 005062132

Loss Location Description of Loss : CHAMPION FOREST DR HOUSTON,TX

: ALLEGEDLY VEH 1 WAS STOPPED AT A LIGHT WHEN LV REAR ENDED VEH

Insured Driver

TAFILAJ DURIM

RISK ANALYSIS INFORMATION:

| Level 1: | | | | |
|----------|--|------|-------|------|
| Level 2: | | | | |
| Level 3: | | | | |
| Level 4: | | | ***** | |
| Level 5: | | | | |
| Level 6: | | | | |

Thank you for allowing us to serve you on this claim. Please contact me if you have any questions or comments.

Sincerely, JANET BROWN FAST TRACK REP 251-PC OVERLAND PARK, KS (913) 338-9224 JANET.BROWN@AIG.COM cc: INSURANCE ALLIANCE Original





AIG Domestic Claims, Inc. Property/Casualty Division

P.O. Box 25588 Shawnee Mission, KS 66225 (800) 242-2987 (all other) Fax (866) 723-0109 (new losses) Fax (866) 854-4926

AUTOMOBILE LIABILITY NEW CLAIM ACKNOWLEDGEMENT

December 31, 2008

CES ENVIRONMENTAL SERVICES INC 4904 GRIGGS RD HOUSTON, TX 77021

RE:

Insured

: CES ENVIRONMENTAL SERVICES INC

Carrier

: Commerce & Industry

Date of Loss Claim Number 12/26/2008

Date Reported

: 12/26/2008

Date Received

: 12/26/2008

This letter will confirm receipt of the above referenced claim.

ADDITIONAL CLAIM INFORMATION:

Policy Number

: 005062132

Loss Location

: CHAMPION FOREST DR HOUSTON, TX

Description of Loss

: ALLEGEDLY VEH 1 WAS STOPPED AT A LIGHT WHEN I/V REAR ENDED VEH

Insured Driver

TAFILAJ DURIM

RISK ANALYSIS INFORMATION:

| Level 1: | | | |
|----------------------|--|--|------|
| Level 2: | | | |
| Level 2: Level 3: | | | |
| Level 4: | | | |
| Level 5: | | | |
| Level 6: | | | |

CLAIMANT INFORMATION:

| Symb <u>ol</u> | Name | | <u>MJC</u> |
|----------------|------------------|-----------|------------|
| 001 | QAID ZOHAR | | 006 |
| 002 | MURTAZA ZOHAR | | 007 |
| 003 | CES ENVIRONMENTA | L SERVICE | 009 |

If you have any comments or questions, please feel free to contact me. Kindly refer to the above claim number on any correspondence.

Sincerely, JANET BROWN FAST TRACK REP 251-PC OVERLAND PARK, KS (913) 338-9224 JANET.BROWN@AIG.COM cc: INSURANCE ALLIANCE Original

EPAHO042001910

Juan Frias 2-2-09

EPAHO042001911



AIG Domestic Claims, Inc.

Property/Casualty Division

P.O. Box 25588 Shawnee Mission, KS 66225

(800) 242-2987

(all other) Fax (866) 723-0109 (new losses) Fax (866) 854-4926

AUTOMOBILE LIABILITY NEW CLAIM ACKNOWLEDGEMENT

February 27, 2009

CES ENVIRONMENTAL 4904 GRIGGS RD HOUSTON, TX 77021-3208 Attn: GREG BOWMAN

RE:

Insured

: CES ENVIRONMENTAL SERVICES INC

Carrier

: Commerce & Industry

Date of Loss

: 02/02/2009

Date Reported

: 02/26/2009

Claim Number

(b) (4)

Date Received

: 02/26/2009

This letter will confirm receipt of the above referenced claim.

ADDITIONAL CLAIM INFORMATION:

Policy Number

: 005062132

Loss Location

: HWY 225 PASADENA, TX

Description of Loss

: I/V REAR ENDED VEH 1

Insured Driver

: FRIAS JUAN

RISK ANALYSIS INFORMATION:

| DIVISION: | | <u> </u> | | |
|-------------|------|----------|--|--|
| LOCATION: | | | | |
| DEPARTMENT: | | | | |
| SECTION: | | | | |
| LEVEL 5: | | | | |
| LEVEL 6: | | | | |

CLAIMANT INFORMATION:

Symbol

Name

001

MECHANICAL REPAIR ENGINEERING 002 CES ENVIRONMENTAL SERVCIES

MJC 007

009

If you have any comments or questions, please feel free to contact me. Kindly refer to the above claim number on any correspondence.

Sincerely, ROBERT HARWELL FAST TRACK REP 251-PC OVERLAND PARK, KS (913) 338-9206 ROBERT.HARWELL@AIG.COM Original

Reinbursent for sepuis & Tele 1977 3-20-09

EPAHO042001913

NJ 07303-2017

(AICCO)

ABOVE ADDRESS ONLY FOR RETURNS

#8177

CES ENVIRONMENTAL 4904 GRIGGS ROAD HOUSTON TX 77021

Remittance -

COMMERCE AND INDUSTRY INSURANCE CO.

No.: 31710126 RFP No.: 00324716

05/15/2009 05/15/2009

insured: CES ENVIRONMENTAL SERVICES INC

Claimant: CES ENVIRONMENTAL

Claim Office:

684

Producer:

000005062132

REIMBRUSEMENT FOR REPAIR TO 1977 TRAILER

Policy Claim Sym. DOL Typ

Sym. DOL TYP S
01 03/20/2009 IND C

Amount

\$12,649.00

Use file # 684-00277424 on all correspondence, for prompt processing. For check information call: 800-242-2987

THIS EQUIMENT CONTAINS A CUSTOM COLORED BACKGROUND AS A SECURITY FEATURE 51-44/119 COMMERCE AND INDUSTRY INSURANCE CO. Check No.: 31710126 Claim No.: 00277424 05/15/2009 00324716 REIMBRUSEMENT FOR REPAIR TO 1977 TRAILER Tado. (5.4) Swelve Thousand Six Hundred Forty Nine Dollars and Cents** τö CES ENVIRONMENTAL *********\$12,649.00 THE 4904 GRIGGS ROAD 684 ORDER JOUSTON VOID AFTER NINETY DAYS BANK OF AMERICA HARTFORD CTAUTHORIZED SIGNATURE

#31710126#

EPAHO042001914

Shawnee Mission, KS 66225 (800) 242-2987 (all other) Fax (866) 723-0109 (new losses) Fax (866) 854-4926

AUTOMOBILE LIABILITY **CLOSED CLAIM NOTICE**

May 15, 2009

CES ENVIRONMENTAL 4904 GRIGGS RD HOUSTON, TX 77021-3208 Attn: GREG BOWMAN

RE:

Insured

: CES ENVIRONMENTAL SERVICES INC

Carrier

: Commerce & Industry

Date of Loss Claim Number

: 03/20/2009 (b) (4)

Date Reported

: 05/12/2009

Date Received

: 05/12/2009

The above captioned claim has been closed. The following amounts were paid on the claim:

Symbol Claimant

MJC

Indemnity

Legal

Medical

001 **CES ENVIRONMENTAL** 009 \$12,649.00

ADDITIONAL CLAIM INFORMATION:

Policy Number

005062132

Loss Location

: 2420 S GULFWAY DR PORT ARTHUR, TX

Description of Loss

: I/V TRAILER WAS DAMAGED WHILE TAKING OFFFROM TRACTOR

Insured Driver : UNKNOWN UNKNOWN

RISK ANALYSIS INFORMATION:

| MSK ANALISIS INFORMATION: | | | | | | |
|---------------------------|--|--|--|--|--|--|
| Level 1: | | | | | | |
| Level 2: | | | | | | |
| Level 3: | | | | | | |
| Level 4: | | | | | | |
| Level 5: | | | | | | |
| Level 6: | | | | | | |

Thank you for allowing us to serve you on this claim. Please contact me if you have any questions or comments.

Sincerely, **DAVID BARRETT** FAST TRACK REP 251-PC OVERLAND PARK, KS (913) 338-9275 DAVID.BARRETT2@AIUHOLDINGS.COM Original

Shawnee Mission, KS 66225 (800) 242-2987 (all other) Fax (866) 723-0109 (new losses) Fax (866) 854-4926

AUTOMOBILE LIABILITY NEW CLAIM ACKNOWLEDGEMENT

May 15, 2009

CES ENVIRONMENTAL 4904 GRIGGS RD HOUSTON, TX 77021-3208 Attn: GREG BOWMAN

RE:

Insured

: CES ENVIRONMENTAL SERVICES INC

Carrier

: Commerce & Industry

Date of Loss

: 05/13/2009

Date Reported

: 05/14/2009

Claim Number

(b) (4)

Date Received

: 05/14/2009

This letter will confirm receipt of the above referenced claim.

ADDITIONAL CLAIM INFORMATION:

Policy Number

: 005062132

Loss Location

: I-45 SOUTH & 610 LOOP HOUSTON,TX

Description of Loss

: O/V CLAIMS THAT SOMETHING (GLOVE) CAME OFF OF THE I/V TRAILER

AND HIT THE DRIVER REAR OF O/V

Insured Driver

: UNKNOWN UNKNOWN

RISK ANALYSIS INFORMATION:

| Level 1: | |
|----------------------|--|
| Level 2: | |
| Level 3: | |
| Level 4: | |
| Level 5: Level 6: | |
| Level 6: | |

CLAIMANT INFORMATION:

001

Symbol Name

RICKY DAVIS

MJC 007

If you have any comments or questions, please feel free to contact me. Kindly refer to the above claim number on any correspondence.

Sincerely. **BRUCE WURTZ** FAST TRACK REP 251-PC OVERLAND PARK, KS (913) 338-9277 BRUCE.WURTZ@AIUHOLDINGS.COM Original

P.O. Box 25588 Shawnee Mission, KS 66225 (800) 242-2987 (all other) Fax (866) 723-0109 (new losses) Fax (866) 854-4926

AUTOMOBILE LIABILITY CLOSED CLAIM NOTICE

May 19, 2009

CES ENVIRONMENTAL 4904 GRIGGS RD

HOUSTON, TX 77021-3208 Attn: GREG BOWMAN

RE:

Insured

: CES ENVIRONMENTAL SERVICES INC

Carrier

: Commerce & Industry

Date of Loss

: 05/13/2009

Date Reported

: 05/14/2009

Claim Number

(b) (4)

Date Received

Indemnity

: 05/14/2009

The above captioned claim has been closed. The following amounts were paid on the claim:

Symbol Claimant

MJC

Medical

Legal

001 RICKY DAVIS 007

ADDITIONAL CLAIM INFORMATION:

Policy Number

: 005062132

Loss Location

: 1-45 SOUTH & 610 LOOP HOUSTON,TX

Description of Loss

: O/V CLAIMS THAT SOMETHING (GLOVE) CAME OFF OF THE I/V TRAILER

AND HIT THE DRIVER REAR OF O/V

Insured Driver

: UNKNOWN UNKNOWN

RISK ANALYSIS INFORMATION:

| Level 1: | | | • |
|----------------------|--|------|-------|
| Level 2: | | | _ |
| Level 3: | | | |
| Level 3: Level 4: | | | - |
| Level 5: | | | |
| Level 6: | | · | |

Thank you for allowing us to serve you on this claim. Please contact me if you have any questions or comments.

Sincerely, **BRUCE WURTZ** FAST TRACK REP 251-PC OVERLAND PARK, KS (913) 338-9277 BRUCE.WURTZ@AIUHOLDINGS.COM Original

Beijamin Mata Accident 4-6-07

EPAHO043000001

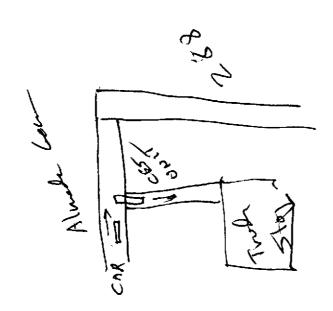


Benjamin mata's accident

4-6-07

7:50am

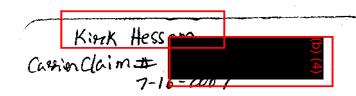
288



| LOADING FROM (i.e. Tank): SIZE OF FITTING: TYPE OF FITTING: | CAN CUSTOMER LOAD WITH FORKLIFT: YES NO Note: Pallets are only good if they drive the forklift into the trailer. Otherwise, it is a huge and painful experience for the driver. If pallets are used, then the drums must be shrink wrapped. |
|---|--|
| FIELD SERVICE WORK | |
| HELPER REQUIRED: YES NO IF YES, I | HOW MANY? 0 |
| EQUIPMENT NEEDED: | : . ··· |
| , | |

Friday, March 30, 2007

Page 2 of 2



Ref: Kirch Hesson

Edel

Adela - 972-341-9253

Adela Garcia

Concenta

Send the specified copies to your Workers' Compensation Insurance Carrier and the injured employee.

*Employers - Do not send this form to the Texas Workers' Compensation Commission, unless the Commission specifically requests a direct filling.

| TWCC CLAIM# | | |
|------------------|-------------|--|
| CARRIER'S CLAIM# | 99H: 497534 | |

| | | EMPLO' | YER'S FIRST RE | PORT C | F INJURY OR ILLNE | SS | | |
|---|-----------------------|------------|---------------------------------------|-----------|----------------------------------|-----------------------|----------------|------------------------------|
| 1. Name (Last, First, M.I.) | | 2. Sex | | 7 | 15. Date of Injury | 16. Time of Injury | 17. Date Lost | Ţime |
| Hessom Kizz | b C. | | □FØM | 1 | 7-16-2007 | ☑ am ☐ pm | | <i> </i> A |
| 3. Social Security No. | 4. Home Phone | 5 Date | of Birth | 1 | 18. Nature of Injury* | 19. Part of Body In | jured or Expos | sed* |
| (b) (4) | | | | | Insect Bite | Right arm | | |
| 6. Does the Employee Sp | eak English? If No | o, Specify | Language | 1 | 20. How and Why Injury | y/Illness Occurred* | | |
| IX Ye | = | | • | | Was working | in the main | rte nance | shop |
| 7. Race | 8. Ethnicity | <u> </u> | | 1 | 23. Address Where Inju | ry or Exposure Occ | urred | |
| WHITE | NIA | | | | Name of business in | fincident occurred of | | |
| 9. Mailing Address Street | et ni P.O. Box | | | 1 | City | State | Zip | |
| PO BOX 87251 | | | | _ | Houston | | 77021 | |
| City | State | Zip | County | | 24. Cause of Injury(fall, | tool, machine, etc.) |)* | 1 |
| Houston | <u> ナメ ・</u> | 7728 | 7 Hathis | 4 | NONE | • | | |
| 10. Marital Status: | Shillana a | 140 Cma | unala Nama | 4 | OF Control | | | |
| 11. Number of Dependent | Children | 12. Spo | use's Name | !: | 25. List Witnesses: | NONE | | |
| 13. Doctor's Name: | | | | _ | 26. Return to work | 27. Did employee | · . | 28. Date |
| 14. Doctor's Mailing Addre | ss (Street or P.O.Bo | x) | | | Date/or expected | die? | visor's name | Reported |
| | | | | | SAME DAY | N 0 | Brian | 7-16-07 |
| City | State | Zip | | | | | | |
| 30. Date of Hire | 31. Was employed | hired or | recruited in | [32 Lan | gth of Service in | 33. Length of Sen | rice in Occurs | ation |
| (b) (4) | Texas? | Ye | _ | | rent Position (mm/yy) | (marries) | /00 | Alon |
| 34. Employee Payroll Clas | sification Code | | | 35. Occ | upation of Injured Works | L | <u>′</u> | |
| 36. Rate of Pay at this job | 37. Full Work We | ek is: | 38. Last Paycheck | | 39. Is employee an Ow | | porate Office | ? |
| Hour Weekly | Hours 40 | Days 5 | Hours 52.6 | Days 5 | | ☐ Yes | No | |
| 40. Nam <mark>e and Titl</mark> e of Pers Prabhakaz R.7 | on Completing Forn | HSF | Manager | 41. Nan | ne of Business ES ENVITION IN | rental Servi | ces Inc | • |
| 42. Business Mailing Addre | ess and Telephone | Vumber | | | iness Location (If differe | | | |
| 4904 Gaiggs Ri | vc-d | Tel No: | 713-676-1460 | | | | , | |
| City Houston | State プダ | Zip 77 | ozi | City | State | _ | Zip | |
| 44. Federal Tax Identification 76 - 0592985 | on Number | | ary Standard Indus Code* (4 digit) | 1542 | 2 (4 digit) | ific SIC Code* | paver No. / | omptroller Tax 7605929854 |
| 48. Workers' Compensation Insurance Company Totas Nutral 49. Policy Number TSF 000 1086044 | | | | | | | | |
| 50. Did you request accider Yes No | nt prevention service | | | | | | · | |
| 1. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING) | | | | | | | | |
| x Dobh | | | | | Date | 7-16-07 | | - |
| | | | | | | | | |

You may be entitled to know what information UT Arlington (UTA) collects concerning you. You may review and have UTA correct this information according to procedures set forth in UT System BPM #32. The law is found in sections 552.021, 552.-23 and 559.004 of the Texas Government Code.

Continued on next page

******* -IND. XMT JOURNAL- ******** DATE JUL-27-2007 **** TIME 10:06 ******

DATE/TIME = JUL-27-2007 10:05

JOURNAL No. = 066

COMM. RESULT = OK

PAGE(S) = 002

DURATION = 00:00:24

FILE No. = 590

MODE = MEMORY TRANSMISSION

DESTINATION = 15122243889

RECEIVED ID

RESOLUTION = STD

-CES Environmental Svcs. -

***** DP-3030 **************

_ ***** _

7137488664- *******

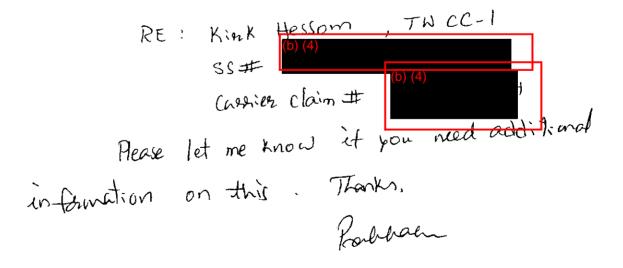
CES Environmental Services, Inc.

4904 Griggs Road Houston, TX 77021 Phone: (713) 676-1460 Fax: (713) 676-1676

Fax

| To: Ms. Angie Balderas | From: Prabhakar R. Thangudu (b) (4) |
|-------------------------|--------------------------------------|
| Fax: 512-224-3889 | Pages: |
| Phone: 512 - 224 - 3800 | Date: 7-27-07 |

Ms. Baldenas:



Employee - You are required to your employer has workers 🖏

rt your injury to your employer within 30 days if ्रम्ला**on insurance**. You have the right to free assistance from the Texas Worke. Ompensation Commission and may be entitled to certain medical and income to sits. For further information call your local Commission field office or 1(800)-2: $\frac{1}{L}$ -7031.



Trabajador - Es necesario que usted reporte su lesión a su empleador dentro de 30 días a partir del día en que se lesionó, si su empleador tiene seguro de compensación para trabajadores. la Comisión Tejana de Compensación para Trabajadores le ofrece asistencia gratuita, también puede que usted tenga derecho a ciertos beneficios médicos y monetarios. Para mayor información llame a la oficina local de la Comisión 1-800-252-7031.

| | S' COMPENSATION WORK STAT | US REPORT |
|--|--|--|
| PART MASIENE RAN IN MISIODALA MISION | octor's Name and Degree in M. Sanchez, MD | (for transmission Date Being Sent purposes only) 07/17/2007 |
| 301 | linic/Facility Name | 9. Employer's Name |
| Vid. C. Hansam | C - Houston Hobby | CES Environmental |
| | inic/Facility/Doctor Phone & Fax | 10. Employer's Fax # or Email Address (if known) |
| 07/1 6/200 7 , (b) (4) (71 | 3)944-4442 (713)944-4582 | (713)676-1676 |
| / | inic/Facility/Doctor Address (street address) | 11. Insurance Carrier |
| Patienfristates: "Patient was at work and bitten by a 850 spid@r" | 5 Gulf Frwy Ste F | Texas Mutuai Insurance Company |
| Lity | State Zip | 12. Carrier's Fax # or Email Address (if known) |
| Hou | ston TX 77017 | (512)322-3889 |
| | ULLY COMPLETE ONE INCLUDING ESTIMATED DATES | AND DESCRIPTION IN 13(c) AS APPLICABLE) |
| 13. The injured employee's medical condition resu | | |
| | as of 07/17/2007 (date) without restrictions. as of (date) with the restrictions | identified in PART III, which are |
| (b) will allow the employee to return to work expected to last through | | identified in PART in, which are |
| | yee from returning to work as of | (date) and is expected to continue |
| | g describes how this injury prevents the employed | |
| | | |
| PART III: ACTIVITY RESTRICTIONS* (REC | DUIRED IF BOX 13(b) IS CHECKED) | - |
| | | 40 MICC PROTRICTIONS (5 mm) |
| 14. POSTURE RESTRICTIONS (if any) : | 17. MOTION RESTRICTIONS (if any): | 19. MISC. RESTRICTIONS (if any): |
| Max Hours per day: 0 2 4 6 8 Other | Max Hours per day: 0 2 4 6 8 Other | Max hours per day of work: |
| Standing | Walking | Sit/Stretch breaks ofper |
| Sitting | Climbing stairs/ladders | Must wear splint/cast at work |
| Kneeling/Squatting | Grasping/Squeezing | Must use crutches at all times |
| Bending/Stooping | Wrist flexion/extension | No driving/operating heavy equipment |
| Pushing/Pulling | Reaching | Can only drive automatic transmission |
| Twisting | Overhead Reaching | No work/hours/day work: |
| Other: | Keyboarding \(\bigcap \) | in extreme hot/cold environments |
| | | at heights or on scaffolding |
| 15. RESTRICTIONS SPECIFIC TO (if applicable | 18. LIFT/CARRY RESTRICTIONS (if any): | Must keep |
| L Hand/Wrist R Hand/Wrist L Arm R Arm Neck | May not lift/carry objects more thanlbs | - |
| | for more thanhours per day | |
| L Leg R Leg Back | | No skin contact with: |
| L Foot/Ankle R Foot/Ankle | May not perform any lifting/carrying | Dressing changes necessary at work |
| Other: | Other: | No running |
| 16. OTHER RESTRICTIONS (if any): | | 20. MEDICATION RESTRICTIONS(if any): |
| REGULAR ACTIVITY, RELEASED FROM CARE. | | Must take prescription medication(s) |
| | | Advised to take over-the-counter meds |
| | nding of the employee's essential job functions. If a particular | |
| | ied duty that meets these restrictions is not available, the pat | ient safety/driving (ssues) |
| should be considered to be off work. Note - these restriction | ns should be followed outside of work as well as at work. | |
| PART IV: TREATMENT/FOLLOW-UP APPO | DINTMENT INFORMATION | |
| • • • | xpected Follow-up Services Include: | } |
| | luation by the treating doctor on | |
| L Re | | (date) at am/pm |
| | ysical medicineX per week forweeks starting | |
| | ecial studies (list):ne. This is the last scheduled visit for this problem. | on (date) at am/pm |
| Date / Time of Visit EMPLOYEE'S SIGNATURE | | |
| 07/17/2007 08:46 am | | ole of Doctor: Treating doctor Referral doc |
| Discharge Time | - | Carrier-selected RME |
| 07/17/2007 09:00 am | K Follow-up | DWC-selected RME |

DWC FORM-73 (Rev. 10/05) Page 1



DIVISION OF WORKERS' COMPENSATION

Claim Number: Concentra Medical Centers

8505 Gulf Frwy Ste F Houston, TX 77017

Service Date: 07/17/2007 Case Date: 07/16/2007

Ext.:

Phone: (713) 944-4442 Fax: (713) 944-4582

Physician Activity Status Report

Employer Location: CES Environmental Address:

4904 Griggs Rd HOUSTON, TX 77021 Contact: Marlin Moser Role: **Primary Contact**

Auth, by: Health Safety Manager Phone: (281) 785-0764 (713) 676-1676

This Visit: Time In: 08:25 am Time Out: 09:00 am Recordable: No Visit Type: Recheck

Treating Provider: Richard Patrick, PA-C **Medications:**

Diagnosis: 913.4

□ Dispensed Over-The-Counter Prescription

☐ Written Prescription given to Patient

Patient Status:

Hessom, Kirk C.

Patient: SSN:

Address

Home: Work:

Regular Activity - Released from care

Ext.:

Return to regular duty on 07/17/2007

Remarks:

Employer Notice:

The prescribed activity recommendations are suggested guidelines to assist in the patient's treatment and rehabilitation. Your employee has been informed that the activity prescription is expected to be followed at work and away from work.

Anticipated Date of Maximum Medical Improvement:

Actual Date of Maximum Medical Improvement: 07/17/2007

Next Visit(s):

It is essential to your recovery that you keep your scheduled appointments, but should you need to reschedule or cancel your appointment, please contact the clinic. Thank you for your cooperation.

Employee - You are required to report your injury to your employer within 30 days if your employer has workers' compensation insurance. You have the right to free assistance from the Texas Workers' Compensation Commission and may be entitled to certain medical and income benefits. For further information call your local Commission field office or 1(800)-252-7031.



Trabajador - Es necesario que usted reporte su lesión a su empleador dentro de 30 días a partir del día en que se lesionó, si su empleador tiene seguro de compensación para trabajadores. la Cornisión Tejana de Compensación para Trabajadores le ofrece esistencia gratuita, también puede que usted tenga derecho a ciertos beneficios médicos y monetarios. Para mayor información tieme a la oficina local de la Comisión 1-600-252-7031.

| _ TEXAS WORKE | RS' COMPENSATION WORK STA | TUS REPORT |
|---|---|--|
| | 5. Doctor's Name and Degree John M. Sanchez, MD | (for transmission Date Being Sent purposes only) |
| 1. Injured Employee's Name | . Clinic/Facility Name | 9. Employer's Name |
| Kirk C. Hessom | CMC - Houston I-10 East | CES Environmental |
| (b) (1) | . Clinic/Facility/Doctor Phone & Fax (713)973-7943 (713)973-7947 | 10. Employer's Fax # or Email Address (if known) (713)676-1676 |
| | Clinic/Facility/Doctor Address (street address) | 11. Insurance Carrier |
| | 10909 I-10 East Frwy | Texas Mutual Insurance Company |
| Insides * | rity State Zip | 12. Carrier's Fax # or Email Address (if known) |
| | Houston TX 77029 | (512)322-3889 |
| PART II: WORK STATUS INFORMATION | (FULLY COMPLETE ONE INCLUDING ESTIMATED DATE | S AND DESCRIPTION IN 13(c) AS APPLICABLE) |
| 13. The injured employee's medical condition re | sulting from the workers' compensation injury: | · |
| | rk as of(date) without restrictions. | |
| — • • • • • • • • • • • • • • • • • • • | rk as of 07/16/2007 (date) with the restrictions | identified in PART III, which are |
| expected to last through _07/30/2007 | _(date). | |
| 11 | ployee from returning to work as of | |
| through(date). The follow | ving describes how this injury prevents the employ | ee from returning to work: |
| | | |
| PART III: ACTIVITY RESTRICTIONS* (F | EQUIRED IF BOX 13(b) IS CHECKED) | |
| | | 40 MICC PECTRATIONS (V) |
| 14. POSTURE RESTRICTIONS (If any): | 17. MOTION RESTRICTIONS (if any): | 19. MISC. RESTRICTIONS (if any): |
| Max Hours per day: 0 2 4 6 8 Other | Max Hours per day: 0 2 4 6 8 Other | Max hours per day of work: |
| Standing UUUU | Walking LLLLL | Sit/Stretch breaks ofper |
| Sitting UUUUU | Climbing stairs/ladders | Must wear splint/cast at work |
| Kneeling/Squatting | Grasping/Squeezing | Must use crutches at all times |
| Bending/Stooping 🔲 🔲 📗 | Wrist flexion/extension | No driving/operating heavy equipment |
| Pushing/Pulling | Reaching | Can only drive automatic transmission |
| Twisting | Overhead Reaching | No work/ hours/day work: |
| | | |
| Other: | Keyboarding | in extreme hot/cold environments |
| 15. RESTRICTIONS SPECIFIC TO (if applicat | ole): Other: | at heights or on scaffolding |
| ☐ L Hand/Wrist ☐ R Hand/Wrist | 18. LIFT/CARRY RESTRICTIONS (if any): | X Must keep wound |
| LArm RArm Ne | ck May not lift/carry objects more thanlb | Elevated Clean & Dry |
| LLeg RLeg Ba | ck for more thanhours per day | No skin contact with: |
| L Foot/Ankle R Foot/Ankle | May not perform any lifting/carrying | Dressing changes necessary at work |
| Other: | Other: | No running |
| 16. OTHER RESTRICTIONS (if any): | | 20. MEDICATION RESTRICTIONS(if any): |
| no driving, no working around electicity, no oper | ating any machines, | Must take prescription medication(s) |
| | | Advised to take over-the-counter meds |
| *These restrictions are based on the doctor's best unde | rstanding of the employee's essential job functions. If a partic | ular Medication may make drowsy (possible |
| restriction does not apply, it should be disregarded. If m | odified duty that meets these restrictions is not available, the | , <u> </u> |
| should be considered to be off work. Note - these restri | tions should be followed outside of work as well as at work. | Salety/dilving issues/ |
| PART IV: TREATMENT/FOLLOW-UP AP | POINTMENT INFORMATION | |
| 21. Work Injury Diagnosis Information: 22. | Expected Follow-up Services Include: | |
| 913.4 Insect Bite, Nonvenomous Of Elbow, For | valuation by the treating doctor on 07/17/2007 | (date) at 08:00 am am/pm |
| | Referral to/Consult withon | |
| · - | Physical medicineX per week forweeks start. | ing on (date) at am/pm |
| , | Special studies (list): | on (date) at am/pm |
| | None. This is the last scheduled visit for this problem. | |
| Date / Time of Visit EMPLOYEE'S SIGNATURE 07/16/2007 11:25 am | - (| Role of Doctor: Treating doctor Referral d |
| Discharge Time | <u>X</u> Initial | ☐ Carrier-selected RME ☐ Consulting dector |
| 07/16/2007 12:51 pm | ☐ Follow-up | DWC-selected RME Other doctor |

DWC FORM-73 (Rev. 10/05) Page 1



DIVISION OF WORKERS' COMPENSATION

Claim Number:

Concentra Medical Centers

10909 f-10 East Frwy Houston, TX 77029 Phone: (713) 973-7943 Fax: (713) 973-7947

Service Date: 07/16/2007

Case Date: 07/16/2007

| | | ı P |
|---------|-------------------|-----|
| Patient | : Hessom, Kirk C. | |
| SSN: | (b) (4) | |
| Addres | s: | |
| | | |
| Home: | |] |
| Work | Evt : | |

hysician Activity Status Report

Employer Location: CES Environmental Address:

4904 Griggs Rd

Contact: Marlin Moser Role:

Primary Contact Phone: (281) 785-0764 Ext.:

HOUSTON, TX 77021 Health Safety Manager

(713) 676-1676 Fax:

This Visit: Time In: 11:05 am Time Out: 12:51 pm Recordable: No Visit Type: New

Auth. by:

Treating Provider: John M. Sanchez, MD Medications:

Insect Bite, Nonvenomous Of Elbow, Forearm, And Wrist, \(\text{t}\) Diagnosis: 913.4

☐ Dispensed Prescription Medication to Patient □ Dispensed Over-The-Counter Prescription

■ Written Prescription given to Patient

Patient Status:

Modified Activity - Returning for follow-up visit

Restricted Activity (In effect until next physician visit):

Return to work on 07/16/2007 with the following restrictions Keep wound clean and dry

Remarks: No driving, No working around electricity, No operating any machines.

Employer Notice:

The prescribed activity recommendations are suggested guidelines to assist in the patient's treatment and rehabilitation. Your employee has been informed that the activity prescription is expected to be followed at work and away from work.

Anticipated Date of Maximum Medical Improvement: 07/30/2007 Actual Date of Maximum Medical Improvement:

Next Visit(s):

Patient Notice: It is essential to your recovery that you keep your scheduled appointments, but should you need to reschedule or cancel your appointment, please contact the clinic. Thank you for your cooperation.

Tuesday July 17, 2007 8:00 am

Provider/Facility: John M. Sanchez, MD



Date of Service: 07/16/2007 Date of Injury: 07/16/2007

Attn: Marlin Moser CES Environmental 4904 Griggs Rd HOUSTON, TX 77021

Dear Marlin Moser:

Your employee Kirk C. Hessorn received treatment for a new work related injury at our CMC - Houston I-10 East clinic on 07/16/2007.

The billings for this injury care will be sent to Texas Mutual Insurance Company. Please help us provide the best care to your injured employee by filing the Employer's First Report of Injury with your carrier, if not already filed. This will ensure timely reporting and management of this workers' compensation claim.

If you have any questions or the above information is incorrect, please call our office or fax any changes to the attention of the Billing Department.

Sincerely,

CMC - Houston I-10 East Central Business Office 800-733-7098 972-458-7678 Employee - You are required to report your injury to your employer within 30 days if your employer has workers' compensation insurance. You have the right to free assistance from the Texas Workers' Compensation Commission and may be entitled to certain medical and income benefits. For further information call your local Commission field office or 1(800)-252-7031.



Trabajador - Es necesario que usted reporte su lesión a su empleador dentro de 30 dias a partir del día en que se lesionó, si su empleador tiene seguro de compensación para trabajadores. la Comisión Tejana de Compensación para Trabajadores le ofrece asistencia gratuita, también puede que usted tenga derecho a ciertos beneficios médicos y monetarios. Para mayor información llame a la oficina local de la Comisión 1-800-252-7031.

| TEXAS WORKE | RS' COMPENSATION WORK STAT | US REPORT | | |
|---|--|--|--|--|
| PART I: GENERAL INFORMATION | 5. Doctor's Name and Degree John M. Sanchez, MD | (for transmission Date Being Sent purposes only) 07/16/2007 | | |
| | 5. Clinic/Facility Name | 9. Employer's Name | | |
| Kirk C. Hessom | CMC - Houston I-10 East | CES Environmental | | |
| Date of Injury 3. Social Security Number 7 | 7. Clinic/Facility/Doctor Phone & Fax | 10. Employer's Fax # or Email Address (if known) | | |
| D7/16/2007 (b) (4) | (713)973-7943 (713)973-7947 | (713)676-1676 | | |
| · · · · · · · · · · · · · · · · · · · | 3. Clinic/Facility/Doctor Address (street address) | 11. Insurance Carrier | | |
| Patient states: "Patient was at work and bitten by a spider " | 10909 I-10 East Frwy | Texas Mutual Insurance Company | | |
| · ' | City State Zip Houston TX 77029 | 12. Carrier's Fax # or Email Address (if known) (512)322-3889 | | |
| | | | | |
| 13. The injured employee's medical condition re (a) will allow the employee to return to we (b) will allow the employee to return to we expected to last through 07/30/2007 (c) has prevented and still prevents the em | ork as of(date) without restrictions. ork as of 07/16/2007 (date) with the restrictions(date). uployee from returning to work as of wing describes how this injury prevents the employee | identified in PART III, which are (date) and is expected to continue | | |
| PARTIII. ACTIVITE RESTRICTIONS (F | | | | |
| 14. POSTURE RESTRICTIONS (if any): | 17. MOTION RESTRICTIONS (if any): | 19. MISC. RESTRICTIONS (if any): | | |
| Max Hours per day: 0 2 4 6 8 Other | Max Hours per day: 0 2 4 6 8 Other | Max hours per day of work: | | |
| Standing \ \ \ \ \ \ \ \ \ \ \ \ | Walking | Sit/Stretch breaks ofper | | |
| Sitting | Climbing stairs/ladders | Must wear splint/cast at work | | |
| | | | | |
| Kneeling/Squatting | Grasping/Squeezing | Must use crutches at all times | | |
| Bending/Stooping | Wrist flexion/extension | No driving/operating heavy equipment | | |
| Pushing/Pulling | Reaching | Can only drive automatic transmission | | |
| Twisting | Overhead Reaching | No work/hours/day work: | | |
| Other: | Keyboarding | in extreme hot/cold environments | | |
| | | at heights or on scaffolding | | |
| 15. RESTRICTIONS SPECIFIC TO (if applica | 18. LIFT/CARRY RESTRICTIONS (if any): | X Must keep wound | | |
| L Hand/Wrist R Hand/Wrist | <u> </u> | | | |
| | ck May not lift/carry objects more thanfbs | | | |
| L Leg R Leg Ba | ick for more thanhours per day | No skin contact with: | | |
| L Foot/Ankle R Foot/Ankle | May not perform any lifting/carrying | Dressing changes necessary at work | | |
| Other: | Other: | No running | | |
| 16. OTHER RESTRICTIONS (if any): | | 20. MEDICATION RESTRICTIONS(if any): | | |
| no driving, no working around electicity, no ope | ration any machines | Must take prescription medication(s) | | |
| The diffing, no working breatile election, no ope | is unit in a contract, | Advised to take over-the-counter meds | | |
| | rstanding of the employee's essential job functions. If a particular | 19 | | |
| | odified duty that meets these restrictions is not available, the pati | ent - | | |
| should be considered to be off work. Note - these restrict | ctions should be followed outside of work as well as at work. | safety/driving issues) | | |
| PART IV: TREATMENT/FOLLOW-UP AF | PROINTMENT INFORMATION | | | |
| | Expected Follow-up Services Include: | | | |
| l la | Evaluation by the treating doctor on 07/17/2007 | (date) at 08:00 am am/pm | | |
| 913.4 Insect Bite, Nonvenomous Of Elbow, Fore Referral to/Consult withon (date) at am/pm | | | | |
| | Physical medicineX per week forweeks starting | ng on (date) at am/pm | | |
| | | on (date) at am/pm | | |
| | None. This is the last scheduled visit for this problem. | | | |
| Date / Time of Visit EMPLOYEE'S SIGNATURE 07/16/2007 11:25 am | \ (<u> </u> | ble of Doctor: Designated doctor Referral doctor | | |
| Discharge Time | | Carrier-selected RME Consulting doctor | | |
| 07/16/2007 12:51 pm | Follow-up | DWC-selected RME | | |
| · | | | | |

DWC FORM-73 (Rev. 10/05) Page 1



DIVISION OF WORKERS' COMPENSATION

To: Dan Bowman 7136761676

Employee - You are required to report your injury to your employer within 30 days if your employer has workers' compensation insurance. You have the right to free assistance from the Texas Workers' Compensation Commission and may be entitled to certain medical and income benefits. For further information call your local commission field office or 1(800):252-7031.



Trabajador - Es necesario que usted reporte su lesión a su empleador dentro de 30 días a partir del día en que se lesionó, si su empleador trene seguro de compensación para trabajadores, la Comisión Tejana de Compensación para Trabajadores le ofrece asistencia gratuita, también puede que usted tenga derecho a cienos beneficios médicos y monetarios. Para mayor información liame a la oficina local de la Comisión 1-800-252-7031.

WARK ATATUA BERART

| TEXAS WORK | ERS COMPENSATION WORK STAT | US REPORT | | |
|--|---|--|--|--|
| PART I: GENERAL INFORMATION | 5. Doctor's Name and Degree John M. Sanchez, MD | (for transmission Date Being Sent purposes only) | | |
| 1. Injured Employee's Name | Clinic/Facility Name | 9. Employer's Name | | |
| Kirk C. Hessom | CMC - Houston Hobby | CES Environmental | | |
| Date of Injury 3. Social Security Number | 7. Clinic/Facility/Doctor Phone & Fax | 10. Employer's Fax # or Email Address (if known) | | |
| o7/16/2007 (b) (4) | (713)944-4442 (713)944-4582 | (713)676-1676 | | |
| Employee's Description of Injury/Accident | Clinic/Facility/Doctor Address (street address) | 11. Insurance Carrier | | |
| Patient states: Patient was at work and bitten by a | 8505 Gulf Frwy Ste F | Texas Mutual Insurance Company | | |
| spider " | City State Zip | 12. Carrier's Fax # or Email Address (if known) | | |
| | Houston TX 77017 | (512)322-3889 | | |
| DADT III WORK STATUS INFORMATION | U (CILLLY COMO) ETE ONE INCLUDING ESTIMATED DATES | AND DESCRIPTION IN 12/5) AC ADDITION IN | | |
| PART II: WORK STATUS INFORMATION (FULLY COMPLETE ONE INCLUDING ESTIMATED DATES AND DESCRIPTION IN 13(c) AS APPLICABLE) 13. The injured employee's medical condition resulting from the workers' compensation injury: X (a) will allow the employee to return to work as of(date) without restrictions. (b) will allow the employee to return to work as of(date) with the restrictions identified in PART III, which are expected to last through(date). (c) has prevented and still prevents the employee from returning to work as of(date) and is expected to continue through | | | | |
| PART III: ACTIVITY RESTRICTIONS* (I | REQUIRED IF BOX 13(b) IS CHECKED) | | | |
| 14. POSTURE RESTRICTIONS (if any) : | 17. MOTION RESTRICTIONS (if any): | 19. MISC, RESTRICTIONS (If any): | | |
| , ,, | | Max hours per day of work: | | |
| Max Hours per day: 0 2 4 6 8 Other | | | | |
| Standing LLLL | _ Walking LILILI | Sit/Stretch breaks ofper | | |
| Sitting | Climbing stairs/ladders | ☐ Must wear splint/cast at work | | |
| Kneeling/Squatting | Grasping/Squeezing | | | |
| | | Must use crutches at all times | | |
| Bending/Stooping | Wrist flexion/extension | No driving/operating heavy equipment | | |
| Pushing/Pulling | Reaching | Can only drive automatic transmission | | |
| | | | | |
| Twisting | Overhead Reaching | No work/ Lhours/day work: | | |
| Other: | Keyboarding UUUUU | in extreme hot/cold environments | | |
| 15. RESTRICTIONS SPECIFIC TO (if applica | Other: | at heights or on scaffolding | | |
| | DR/- | | | |
| L Hand/Wrist R Hand/Wrist | 18. LIFT/CARRY RESTRICTIONS (if any): | Must keep | | |
| LArm RAmm Ne | ck May not lift/carry objects more thanlbs | ☐ Elevated ☐ Clean & Dry | | |
| ∏LLeg ∏RLeg ∏Ba | ck for more thanhours per day | No skin contact with: | | |
| L Foot/Ankle R Foot/Ankle | May not perform any lifting/carrying | | | |
| T TODANNE THE TODANNE | | Dressing changes necessary at work | | |
| Other: | Other: | ☐ No running | | |
| 16. OTHER RESTRICTIONS (If any): | ***** | 20. MEDICATION RESTRICTIONS(If any): | | |
| REGULAR ACTIVITY, RELEASED FROM CAR | r= | Must take prescription medication(s) | | |
| THE OCCUPANT OF THE CONTROL OF THE C | | 1 = 1 | | |
| | | Advised to take over-the-counter meds | | |
| | erstanding of the employee's essential job functions. If a particular | 1 🔲 | | |
| | nodified duty that meets these restrictions is not available, the pa | safety/driving issues) | | |
| should be considered to be on work. Note - these restr | ictions should be followed outside of work as well as at work. | | | |
| PART IV: TREATMENT/FOLLOW-UP AF | POINTMENT INFORMATION | | | |
| | Expected Follow-up Services Include: | | | |
| | Evaluation by the treating doctor on | (date) at am/pm | | |
| 913.4 Insect Bite, Nonvenomous Of Elbow, For | Referral to/Consult withon | (date) atam/pm | | |
| | Physical medicineX per week forweeks starting | · · · · · · · · · · · · · · · · · · · | | |
| | | on (date) at am/pm | | |
| | None. This is the last scheduled visit for this problem. A | | | |
| Date / Time of Visit EMPLOYEE'S SIGNATURE | | ale of Dactor: X Treating doctor | | |
| 07/17/2007 08:46 am | ☐ Initial □ | Designated doctor Referral doctor | | |
| Discharge Time | | Carrier-selected RME | | |
| 07/17/2007 09:00 an | | DWC-selected RME TI Other doctor | | |

DWC FORM-73 (Rev. 10/05) Page 1



DIVISION OF WORKERS' COMPENSATION



EMPLOYER'S AUTHORIZATION FOR EXAMINATION OR TREATMENT

| Patient Name: Kink Hessom Company Name: CES Environmental Services Location #/Street Address: 4904 Griggs Road, H | SSN: (b) (4) Date of Birth: (b) (4) |
|--|---|
| Temporary Staffing Agency: | DOT PHYSICAL |
| Post-Accident Substance Abuse Testing: Drug Screen Spice bita Breath Alcohol Drug Screen and Breath Alcohol Urine Collection Only DOT Regulated | Preplacement Recertification Exit Audiogram Regulated Drug Screen Urine Collection Only Breath Alcohol |
| Non-regulated | |
| PRE-PLACEMENT EVALUATION Job Title: Physical Exam HPE Regulated Drug Screen Non-regulated Drug Screen Urine Collection Only Hair Collection Audiogram I | SUBSTANCE ABUSE TESTING Regulated Non-regulated Urine Collection Only Rapid Test Pre-placement Reasonable Suspicion Random Periodic Post-accident Follow-up |
| SPECIAL PHYSICAL EXAMINATIONS Asbestos Respirator Hazmat Baseline Other | Breath Alcohol BILLING Employee to pay charges at time of service Workers' Compensation Insurance Co: Policy #: Phone #: |
| Authorized By: Robber They A. Phone: 281-433-9792 | Title: HSE Managh Date: 7-16-07 |
| Phone: 281-455-97912 (copies of this form available a | |



4904 Griggs Road Houston, TX 77021 Phone: (713) 676-1460 Fax: (713) 676-1676

Fax

| ^{То:} М5. Д | ngje | Baldena | ડ | From: | Prabi | nakar R | . Thangı | udu | |
|----------------------|-------|-----------------|---------|---------|-------|-------------|----------|-------------|----------|
| Fax: 512 | - Z | 2 <i>4-3</i> 88 | 9 | Pages: | | B 7 | 2 | | |
| Phone: 5 | 12-2 | 24 - 3800 |) | Date: | 8 | - 10-2 | 007 | | |
| Ms. <i>Bo</i> | ilden | • | Kirk | 1) 60 | (Como | ~~ <u>~</u> | \ | otifica | tion for |
| | | K±: | 55# | (b) (4) | 550 W | , LN | <u> </u> | | |
| | | | Carrier | . cla | im # | (b) | (4) | | |
| | | Plea | ne Call | if yo | ou N | eed ou | ddition | al infa | imation |
| | | | | | | Tha | nks, | | |
| | | | | | | Pa | blac | - | |

Employee Acknowledgment of Workers' Compensation Network

I have received information that tells me how to get health care under my employer's workers' compensation insurance.

If I am hurt on the job and live in a service area described in this information, Lunderstand that:

- 1. I must choose a treating doctor from the list of doctors in the network. Or, I may ask my HMO primary care physician to agree to serve as my treating doctor. If I select my HMO primary care physician as my treating doctor, I will call Texas Mutual at (800) 859-5995, extension 2880 to notify them of my choice.
- 2. I must go to my treating doctor for all health care for my injury. If I need a specialist, my treating doctor will refer me. If I need emergency care, I may go anywhere.
- 3. The insurance carrier will pay the treating doctor and other network providers.
- 4. I might have to pay the bill if I get health care from someone other than a network doctor without network approval.
- 5. Making a false or fraudulent workers' compensation claim is a crime that may result in fines and or imprisonment.

| and the second second | 7-02-07 |
|---|----------|
| Signature | Date |
| Link HESS om | |
| Printed Name | |
| I live at: | |
| P.O. Box 87251 | |
| Howton Tx. 77287 | |
| City | Zip Code |
| Name of Employer: CES Envisionmental Services | , Inc · |
| Name of Network: Texas Star Network _{SM} | |
| Network service areas are subject to change. Call (800) 381-8067 if you need a network treating pr | ovider. |
| Please indicate whether this is the: | |
| Initial Employee Notification | |
| ☐ Injury Notification (Date of Injury: 07 / 17 / 200) | 7) |

DO NOT RETURN THIS FORM TO TEXAS MUTUAL INSURANCE COMPANY UNLESS REQUESTED

Employee Notice of Network Requirements - 03/06

Page 8 of 8

******** -IND. XMT JOURNAL- ******** DATE AUG-10-2007 **** TIME 10:17 *******

DATE/TIME = AUG-10-2007 10:17

JOURNAL No. = 055

COMM. RESULT = OK

PAGE(S) = 002

DURATION = 00:00:19

FILE No. = 778

MODE = MEMORY TRANSMISSION

DESTINATION = 15122243889

RECEIVED ID =

RESOLUTION = STD

-CES Environmental Svcs. -

**** DP-3030 ***********

- ***** - 7137488664- *******

CES Environmental
Marlin Moser
4904 Griggs Rd
HOUSTON, TX 77021

1500

HEALTH INSURANCE CLAIM FORM

| PICA PICA | APPLACE | D BY INATIONNAL UNIFOR | SM CLAIM COMMITTEE 08/05 | PICA |
|--|--|------------------------|---|---|
| | HEALTH PLAN | ECA OTHER | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | (FOR PROGRAM IN ITEM 1) |
| (Medicare #) (Medicaid #) (Sponsor's SSN) (PATIENT'S NAME (Last Name, First Name, Middle Initial) | (Mamber (O#) ((SSN or (D) | SSN) X (ID) | 448-86-2987 4. INSURED'S NAME (Last Name, First N | NEU-lla latitat |
| Hessom, Kirk C | (6) (4) | X F | <u> </u> | · |
| PATIENT'S ADDRESS (No Steet) | PATIENTS DELATIONSHIP TO IN | | 7. INSURED'S ADDRESS (No Street) | tal |
| (b) (4) | Self Spouse Child | Other | 4904 Griggs Rd | |
| TY T | STATE 8. PATIENT STATUS | | ary | STATE |
| (b) (4) | Single Married | Other | HOUSTON | TX |
| (2) | Angle | | ZP CODE | TELEPHONE (INCLUDE AREA CODE) |
| 0) (4) | Employed Full-Time Student | Part-Time Student | 77021 | 936 632-1925 |
| OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) | 10. PATIENT'S CONDITION RELATI | | 11, INSURED'S POLICY GROUP OR FECA | A NUMBER |
| N / A | | | | |
| OTHER INSURED'S POLICY OR GROUP NUMBER | a. EMPLOYMENT? (CURRENT OR I | PREVIOUS) | a. INSURED'S DATE OF BIRTH | SEX |
| N / A | X YES | No. | N A | м |
| OTHER INSURED'S DATE OF BIRTH SEX | b. AUTO ACCIDENT? | PLACE (State) | IT. EMPLOYERS NAME OR SCHOOL NAME | ME |
| N / A W | YES | NO . | N/A | |
| EMPLOYERS NAME OR SCHOOL NAME | a OTHER ACCIDENT? | _ | C. INSURANCE PLAN NAME OR PROGRA | M NAME |
| Ņ / A | YES | NO | N/A | |
| NSURANCE PLAN NAME OR PROGRAM NAME | 10d, RESERVED FOR LOCAL USE | | d, IS THERE ANOTHER HEALTH BENEFI | T PLAN? |
| N / A | | | YES NO | If YES, return to and complete items 9a-d. |
| READ BACK OF FORM BEFORE COMPLETING A 2. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release | | to process this state | 15, INSURED'S OR AUTHORIZED PERSO | ON'S SIGNATURE I authorize payment of medical an or supplier for services described below. |
| I also request payment of government benefits either to myself or to the part | | to process this denti. | , | |
| CICUSTOPE ON PILE | 37 / 3 | | GT CNIA | TURE ON FILE |
| SIGNATURE ON FILE | DATE N/A | | SIGNED_STORE | TORE ON FILE |
| DATE OF CURRENT ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR | 15. IF PATIENT HAS HAD SAME OR SIMILA GIVE FIRST DATE MM DO | ₩ | 16. DATES PATIENT UNABLE TO WORK | IN CURRENT OCCUPATION TO MM DD YY |
| 07: 16:2007 PRESNANCY (LMP) NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | 07; 16 | 2007 | 18. HOSPITALIZATION DATES RELATED | N / A |
| The state of the s | 17b, NPI | | FROM MM DD YY | MM DD YY |
| RESERVED FOR LOCAL USE | 172[141] | | N / A | \$ CHARGES |
| | | | YES NO | 1 of partices |
| DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE ITEMS 1,2,3 OR 4 | TO (TEM 24E BY LINE) | | 22. MEDICAID RESUBMISSION | I |
| 1 913.4 | a I | | CODE N / A | ORIGINAL REF. NO. N / A |
| 313.4 | *L | ₩ | 23. PRIOR AUTHORIZATION NUMBER | |
| 2. • | 4. | | N/A | |
| <u> </u> | D | € | · | H I I |
| FROM TO Race | PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) | DIAGNOSIS | I DAYS IE | PSDT ID DENDERING |
| MM DD YYYY MM DD YYYY Service EMG CP | T/HCPCS MODIFIER | POINTER | I UNITSI | Man QUAL PROVIDER ID. # |
| 07 17 07 07 17 07 11 | 99080 73 | 1 | 15.00 1 | NPI MDHO.Za |
| Required report charge/DW | · | 1 * | 13.00 1 | OB MDH078 |
| | 99213 | 1 | 86 06 1 | NPI |
| evel 3 Return Expanded V | isit | | | |
| | | | | NPI |
| | | | Marie Code L | f # |
| | | | | NPI . |
| | | | | 8.00 |
| | | | | NPI |
| The second of the first of the | | | | NPI |
| FEDERAL TAX I.D. NUMBER 26, PATIENT | S ACCOUNT NO. 27 ACCEF | T ASSIGNMENT? | 28, TOTAL CHARGES 29. | AMOUNT PAID . 50, BALANCE DUE |
| 52014828 SSN EN X (b) (4) | For govt. | daims, see back) | 404 100 | 0.00 101.0 |
| SIGNATURE OF PHYSICIAN OR SUPPLIER 32, NAME AT | ND ADDRESS OF FACILITY WHERE SERVICES | | 33. PHYSICIAN'S, SUPPLIER'S BILLING N | |
| VCLUDING DEGREES OR CREDENTALS RENDERE certify that the statements on the reverse apply to this | D (it other than home or office) | | & PHONE #. Occupational He | (800) 733-7098 |
| | - Houston Hobby entra Medical Cent | ers | of the Southwes | |
| 8505 | Gulf Frwy Ste F | | PO Box 9005 | • |
| ohn M Sanchez, MD | ton, TX 77017 | | Addison, TX 750 |)OT-A002 |
| U1/2//2UU/ - | | # | a | ^{b.} MDH0784 |





8505 Gulf Frwy Ste F Houston, TX 77017 (713) 944-4442

Patient

Hessom, Kirk C

Service Date:

07/17/2007

Soc. Sec. # Date of Birth:

Age: 36

Injury Date:

07/16/2007

Service Location:

CMC - Houston Hobby

Employer:

CES Environmental 4904 Griggs Rd

Service ID #:

42821714

Claim #:

HOUSTON, TX 77021

Dictator: Diagnosis: Richard Patrick, PA-C

913.4

Insect Bite, Nonvenomous Of Elbow, Forearm, And Wrist, Withoutmention

Notes: ******** PROGRESS NOTE *******

Vital Signs: BP: 128/88. P: 80 regular. R: 16. T: 98.0 degrees F orally. The vitals were taken at: 8:57 AM by: T A.

Patient returns for a recheck for the injury stated above.

HISTORY OF PRESENT ILLNESS:

He feels the pattern of symptoms is improving and feels better.

PE: Forearm, right

APPEARANCE: Well nourished, well developed, in no acute distress.

VITAL SIGNS: See above.

1mm macular lesion is seen at the distal anterior forearm. No erythema, bleeding SKIN:

or exudate is seen.

PERIPHERAL VASCULAR: Normal pulses distal to injury.

NEUROLOGIC: Normal distal neurovascular.

MUSCULOSKELETAL: No deformity. No swelling. Full ROM.

DIAGNOSIS:1. Insect bite forearm. 913.4.

MEDICAL DECISION MAKING:

Activity Status:

Regular activity release from care today.

Dictated But Not Read

Printed Date:

Dictated By: Richard Patrick, PA-C Supervised by Presiding Physician: John M Sanchez, MD

Dictated On: Jul 17 2007 9:08AM

07/27/2007

Page: 1

Employee - You are required to report your injury to your employer within 30 days if your employer has workers' compensation insurance. You have the right to free assistance from the Texas Workers' Compensation Commission and may be entitled to certain medical and income benefits. For further information call your local Commission field office or 1(800)-252-7031.



Trabajador - Es necesario que usted reporte su lesión a su empleador dentro de 30 días a partir del día en que se lesionió, si su empleador tiene seguro de compensación para trabajadores. la Comisión Tejama de Compensación para Trabajadores le ofrece asistencia gratula, también puede que usted tenga derecho a ciertos beneficios médicos y monetarios. Para mayor información llame a la oficina local de la Comisión I-800-252-7031.

TEXAS WORKERS' COMPENSATION WORK STATUS REPORT

| | I EXAS VV | INNERS | COMPENSA | CHOIN MOKK | SIAI | I US KEPUK I | |
|--|---|--|--|--|----------------------------------|--|---------------------------------------|
| PART I: GENER | RAL INFORMATIO | 3 8 1 | tor's Name and Degree hn M Sanchez, MD | | (for tr | ansmission purpose only) | Date Being Sent 07/27/2007 |
| Injured Employee's Name Kirk C Hessom | e | | c/Facility Name IC - Houston Hobby | | - 1 | mployer's Name ES Environmental | |
| 2. Date of Injury 07/16/2007 | 3. Social Security Number (b) (4) | | ic/Facility/Doctor Phone & F 3)944-4442 | Fax (713)944-4582 | 1 | Employer's Fax # or Email Address (i 713)676-1676 | f known) |
| 4. Employee's Description | of Injury/Accident | 8. Clin | ic/Facility/Doctor Address (| <u>` </u> | 11. (| Insurance Carrier | |
| spider " | nt was at work and bitter | City | 05 Gulf Frwy Ste F State | Zip | | ES Environmental Carrier's Fax # or Email Address (if ki | nown) |
| | | 1 - | ston, TX 77017 | - - | I | 713)575-1676 | |
| PART II: WORK | STATUS INFOR | MATION | (FULLY COMPLETE O | NE INCLUDING ESTIMA | ATED DA | TES AND DESCRIPTION IN 13 | (c) AS APPLICABLE) |
| l — ' ' ' | e's medical condition res | • | • | | | | |
| (b) will allow the en | nployee to return to wo nployee to return to wo | | | | ied in PA | ART III, which are | |
| | ind still prevents the emplo | | | | | | |
| through | _ (date). The following de | scribes how th | nis injury prevents the | e employee from retu | urning to | o work: | |
| | /ITV DESTRICTIO | 7416* 10M | V COMBINETE IF BOY | 12/b) IS CHECKED) | | | |
| 14. POSTURE RESTRIC | VITY RESTRICTIONS (If any): | | 17. MOTION RESTRIC | | | 19. MISC. RESTRICTIONS (if | anv): |
| Max Hours per day: | 0 2 4 6 8 Othe |] | Max Hours per day: | 0 2 4 6 8 Oth | her | Max hours per day of wor | |
| Standing | | | Walking | | | Sit/Stretch breaks of | per |
| Sitting | | | Climbing stairs/Ladders | s | | Must wear splint/cast at | |
| Kneeling/Squatting | | - | Grasping/Squeezing | | | Must use crutches at all t | limes |
| Bending/Stooping | | - | Wrist flexion/extension | | _ | No driving/operating hear | vy equipment |
| Pushing/Pulling | | _ | Reaching | | | Can only drive automatic | Transmission |
| Twisting | | | Overhead Reaching | | | □ No work / □ | hours/day work |
| Other: | | | - Keyboarding | | | in extreme hot/cold er | ıvironments |
| 15. RESTRICTIONS SP | ECIFIC TO (if applicable |): | Other: | | | at heights or on scaffe | olding |
| L Hand / Wrist | R Hand / Wrist | | 18. LIFT/CARRY REST | RICTIONS (if any): | | Must keep | : |
| L Arm | R Arm | Neck [| May not lift/carry obj | ects more than lb | ns. | ☐ Elevated ☐ □ | Clean & Dry |
| L Leg | R Leg | Back | May not lift/carry obj | hours per day | | No skin contact with: | · · · · · · · · · · · · · · · · · · · |
| L Foot/Ankle | R Foot/Ankle |] [| May not perform any | y lifting/carrying | | Dressing changes neces | sary at work |
| Other: | · | [| Olher: | | | ☐ No Running | |
| 16. OTHER RESTRICTI | | | | | | 20. MEDICATION RESTRICT | ` ** |
| REGULAR ACTIVITY, | , RELEASED FROM CAR | E, | | | | Must take prescription me | edication(s) |
| | | | | | | Advised to take over-the- | counter meds |
| * These restrictions are particular restriction do available, the patient sh | e based on the doctor's es not apply, it should b lould be considered to be | best understa e disregarded off work. Note | anding of the employer I, if modified duty that - these restrictions sho | e's essential job function meets these restrictions ould be followed outside | ons. If a s is not of work | Medication may make dro (Possible safety/driving is | - |
| as well as at work | | | | | | | |
| PART IV: TREA | TMENT/FOLLOW | -UP APP | OINTMENT INFO | ORMATION | | | |
| 21. Work Injury Diag | nosis Information: | | ed Follow-up Servic | | | | |
| 913.4 Insect Bite, Non- Forearm, And Wrist, W | venomous Of Elbow, ithoutmention | | | | | ` | te) atam/pm |
| , , | | | | | | | te) at am/pm te) at am/pm |
| | | | | | | | e) at am/pm |
| | | | | | | , no further medical care is antic | |
| Date / Time of Visit | EMPLOYEE'S SIGNATU | ire | DOCTOR'S SIGNA | TURE | <u>Vi</u> sit Typ | | X Treating doctor |
| 07/17/2007 8:47AM | | /N LIEU OF | TREATING PHYSICIA | AN SIGNATURE | ☐ Initial X Follow | Designated doctor | Raferral doctor |
| Discharge Time 07/17/2007 9:00AM | | Je. | 722 | eremmenten | 23. 51101 | DWC-selected RME | Other doctor |
| | | | MEDICAL PROPERTY AND ADDRESS OF THE PERSON NAMED IN COLUMN TO ADDRESS OF THE P | CAL DIRECTOR | | | |
| | | | | | | | |
| | | | | | | | |

Employee - You are required to report your injury to your employer within 30 days if your employer has workers' compensation insurance. You have the right to free assistance from the Texas Department of Insurance, Division of Workers' Compensation and may be entitled to certain medical and insome benefits. For further information call your local Division field office or 1-800-252-7031



Empleado - Es necessaio que usted reporte su lesión a su empleador dentro de 30 días a partir de la fecha en que se lesiono si es que su empleador cuenta com un seguro de compensación para trabajadores. Usted tiene derecho a recibir assistencia gratuita por porte de la División de Compensación para Trabajadores, y también puede tener derecho a ciertos beneficios médicos y monetanos. Para mayor información comuniquese con la oficina local de la División al teléfono 1-800-252-7031.

| Victors Compared Principles Colors 1. Supposed Name 2. Supposed | REPORT OF MEDI | CAL EVALUATION | CLAIM#: |
|--|--|--|---|
| Continued Research Continu | | | |
| CES EVEX.completed. 1. Strongeric Address. 1. Strong | 1: Promero compendador medianes eximer | (| |
| Sorte y 7001 13. Indicate whether the employee has reached Clinical of Stattory MM based upon the following definitions: 14. INTEREST CALIFORNIA THE PROPERTY OF MEDICAL EVALUATION IN complete and economic valuation of using ingrecovered to an injury can no longer reasonably to articipated. 15. Treating Double in a state of the reaching of the re | | | |
| ADDITION TX 7102 IDITION | | | |
| 33. Indicate which role you are serving in the claim in performing bits evaluation. Only a doctor serving in one of the following roles is authorized to evaluate MMMImmagnment and fifth this report (withchese Compensation Rel 1931, openses such authorization); | | (4) | |
| 33. Indicate which role you are serving in the claim in performing this evaluation. Only a doctor serving in one of the following roles is authorized to evaluate MMMImpalament and life this report for Wichers's Compensation Net 1931, opens such authorization; | PART II: DOCTOR'S BOLE AND CERTIE | CATION | |
| Treating Doctor | 13. Indicate which role you are serving in th | e claim in performing this evaluation. Only a | |
| Certifical Macrimum Medical Improvement part in prince of special state of the provision of the special state of t | 1_ | Compensation Rule 130.1 governs such auth | orization): |
| NOTE - [You get not authorized by Rule 130]. If file this report, you will not be paid for this report on the Multimaniment examination. At I HEREPY CENTRY THAT THIS REPORT OF the PROCIAL EVALUATION is completed and accurate and complete with the Traces Workers' Componentation Act and applicable rules, and 1 understand that making a misrepresentation about workers' componentation debrin as a crime that can result in fines and/or imprisonment. Signature of Certifying Doctor: **DECEAL DIRECTOR** **PART III.** MEDICAL STATUS INFORMATION** 15 oP/8r/18697 | | • | |
| applicable rules, and I understand that making a misrepresentation about workers' compensation claim is a crime that can result in fines and/or imprisonment. **WEDICAL DIRECTOR** **PARTITIS** **P | NOTE - If you are not authorized by Rule 130.1 fe | ofile this report, you will not be paid for this report | or the MMI/Impairment examination. |
| Date of Certifying Doctor: Signature | | misrepresentation about workers' compensation | claim is a crime that can result in fines and/or imprisonment. |
| PART II MEDICAL STATUS INFORMATION 15 O'REPATED 16 O'REPATED 16 O'REPATED 16 O'REPATED 16 O'REPATED 16 O'REPATED 16 O'REPATED 17 O'REPATED 17 O'REPATED 18 O'REPAT | Signature of Certifying Docto | W LIEU OF TREATING PHYSICIAN SIGNA | Date of Certification: 07/17/2007 |
| 15. PVPS-75897 (CD-95 colos) (2) 3.3.4. 2 3 9 4) 17. Indicate whether the employee has reached Clinical or Statutory MMI based upon the following definitions: Clinical MMA admirman Medical Emprovement (Clinical MMI) is the series of the admirance of the component to an injury can no tensor reasonable medical probability, further material recovery from or its fing improvement to an injury can no tensor reasonable by the official MMI) was estimated by the Division through operation of Teasts Labor Code \$408.104. Statutory MMI is the later of (f) the end of the 20th sweet whether the date that temporary income benefits (TIBs) began to accrue; or (2) the date to which MMI was estimated by the Division through operation of Teasts Labor Code \$408.104. Statutory MMI is the benefole version of Teasts Labor Code \$408.104. Statutory MMI is the benefole version of Teasts Labor Code \$408.104. Statutory MMI is the benefole version of Teasts Labor Code \$408.104. Statutory MMI is the benefole version of Teasts Labor Code \$408.104. The reason the employee has not reached MMI but is expected to reach MMI on or about | | WEDICAL DIRE | CTOR |
| 15. PVPS-75897 (CD-95 colos) (2) 3.3.4. 2 3 9 4) 17. Indicate whether the employee has reached Clinical or Statutory MMI based upon the following definitions: Clinical MMA admirman Medical Emprovement (Clinical MMI) is the series of the admirance of the component to an injury can no tensor reasonable medical probability, further material recovery from or its fing improvement to an injury can no tensor reasonable by the official MMI) was estimated by the Division through operation of Teasts Labor Code \$408.104. Statutory MMI is the later of (f) the end of the 20th sweet whether the date that temporary income benefits (TIBs) began to accrue; or (2) the date to which MMI was estimated by the Division through operation of Teasts Labor Code \$408.104. Statutory MMI is the benefole version of Teasts Labor Code \$408.104. Statutory MMI is the benefole version of Teasts Labor Code \$408.104. Statutory MMI is the benefole version of Teasts Labor Code \$408.104. Statutory MMI is the benefole version of Teasts Labor Code \$408.104. The reason the employee has not reached MMI but is expected to reach MMI on or about | PART III: MEDICAL STATUS INFORMATI | ON | |
| Clinical Maximum Medical Improvement (Clinical MMI) is the earliest date after which, based upon reasonable medical probability, further material recovery from or lasting improvement to an injury can be longer reasonably be anticipated. Statutory MMI is the later of: (1) the earl of the 104th week after the date that temporary income benefits (TIBs) began to accrue; or (2) the date to which MMI was earlied by the Division from they benefit of the wast abort Code \$608.104. [S] Vest, I certify that the employee reached [INTER] or in the attached marrative or eached MMI or its expected to reach MMI on or about [INTER] or the employee has not reached MMI is documented in the attached narrative. NOTE — The fact that an employee reaches either Clinical MMI or Statutory MMI does not signify that the employee is no longer entitled to medical benefits. PARTIVE PERMANENT IMPAIRABENT 18. If the employee has ROT indicated whether the employee has permanent impairment as a result of the compensable injury. Impairment Impairment Impairment as an employee that have the properties of the compensable injury. In pairment Impairment Impairment as an expect of the compensable injury and its reasonably presumed to be permanent. The finding that impaired exists must be made based upon objective clinical or suboratory findings meaning a medical finding of impairment resulting from a compensable injury, because the properties of the compensable injury and the employee has permanent impairment as a result of the compensable injury and the employee of the employee. World | 15 Date of Exam 16. Diagnosis 1) (ICD-9 Codes) 913. | | 3) 4 |
| Trom or lasting improvement to an injury can no longer reasonably be anticipated. Statutory MMI is the later of: (1) the end of the 104th week after the date that temporary income benefits (TIBs) began to accrue; or (2) the date to which MMI was sended by the Division through operation of Texas Labor Code \$408.104. a)[X] ves., tent'thy that the employee reached | 17. Indicate whether the employee has re | eached Clinical or Statutory MMI based u | pon the following definitions: |
| NOTE - The fact that an employee reaches either Clinical MMI or Statutory MMI does not signify that the employee is no longer entitled to medical benefits. PARTIV: PERMANENT IMPAIRMENT 18. If the employee has reached MMI, indicate whether the employee has permanent impairment as a result of the compensable injury. Impairment means any snatomic or functional abnormality or loss existing after MMI that results from a compensable injury and is reasonably presumed to be permanent. The finding that impaired exists must be made based upon objective clinical or alboratory lindings meaning a medical finding of impairment resulting from a compensable injury, based upon competent objective medical evidence that is independently confirmable by a doctor, including a designated doctor, without reliance on the subjective symptoms perceived by the employee. a) 1 certify that the employee does not have any permanent impairment as a result of the compensable injury. OR b) 1 certify that the employee has permanent impairment as a result of the compensable injury. The amount of permanent impairment is determined in accordance with the requirements of the Toxas Workers' Compensation Act and Commission Hust. The attached narrative provides documentation involved in the calculation of the impairment rating assigned using the following edition of the Guides to the Evaluation of Permanent Impairment published by the American Madician Association (AMA): Intrindiction association (AMA): Intrindiction association (AMA): Intrindiction association (AMA): Intrindiction association (AMA): Intrindiction association (AMA): Pertuary 1899. OR fourth edition, 1st, 2nd, 3rd, 4th printing, including corrections and changes issued by the AMA prior to May 16, 2000. PART V: TREATING DOCTOR'S AGREEMENT OR DISAGREEMENT WITH ANOTHER DOCTOR'S CERTIFICATION 19. Treating Doctor's Name and Degree 22 I AGREE / I DISAGREE with the certifying doctor's finding of no impairment. 21. Treating Doctor's Phone & Fax #6 (Ph) | from or lasting improvement to an injury can a Statutory MMI is the later of: (1) the end of extended by the Division through operation of a) X Yes, I certify that the employee reached included documentation relating to this certification | no longer reasonably be anticipated. If the 104th week after the date that temporary in Texas Labor Code §408.104. STATUTORY / X CLINICAL (mark one) Months the attached narrative. OR | come benefits (TiBs) began to accrue; or (2) the date to which MMI was MI on07/17/2007 (may not be a prospective date) and have |
| PARTIV: PERMANENT IMPAIRMENT 18. If the employee has reached MMI, indicate whether the employee has permanent impairment as a result of the compensable injury. Impairment means any anadomic or functional abnormality or loss existing after MMI that results from a componsable injury and is reasonably presumed to be permanent. The finding that impaired exists must be made based upon objective clinical or laboratory fundings meaning a medical finding of impairment resulting from a compensable injury, based upon competent objective medical evidence that is independently confirmable by a doctor, including a designated doctor, without reliance on the subjective symptoms perceived by the employee. a) I certify that the employee does not have any permanent impairment as a result of the compensable injury. Or Discourage that the employee has permanent impairment as a result of the compensable injury. The amount of permanent impairment is \$\frac{1}{2}\$, which was determined in accordance with the requirements of the Taxas Workers' Compensation Act and Commission Rules. The attached narrative provides documentation involved in the calculation of the impairment rating assigned using the following edition of the Suigides to the Suigides to the Suigides to the Suigides of Permanent Impairment published by the American Maglical Association (AMA). If the impairment rating assigned using the following edition of the Suigides to the Suigides to the Suigides of Permanent Impairment published by the American Maglical Association (AMA). For the edition, 1st, 2nd, 3rd, 4th printing, including corrections and changes issued by the AMA prior to May 16, 2000. PART V. TREATING DOCTOR'S AGREEMENT OR DISAGREEMENT WITH ANOTHER DOCTOR'S CERTIFICATION 19. Treating Doctor's Name and Degree 20. Treating Doctor's Name and Degree 21. Treating Doctor's Phone & Fax #8 (Ph) (Facility Advisory) Indicated the Compensation about a workers' compensation claim is a crime that can result in fines and/or imprisonment Signature of Treating Doctor. | documented in the attached narrative. | | |
| 18. If the employee has reached MMI, indicate whether the employee has permanent impairment as a result of the compensable injury. Impairment "means any anatomic or functional abnormality or loss existing after MMI that results from a componeable injury and is reasonably presumed to be permanent. The finding that impaired exists must be made based upon objective officiated or isboratory indings meaning a madical finding of impairment resulting from a compensable injury, based upon competent objective medical evidence that is independently confirmable by a doctor, including a designated doctor, without reliance on the subjective symptoms perceived by the employee. a) | | Clinical MMI or Statutory MMI does not signify tha | t the employee is no longer entitled to medical benefits. |
| Fourth edition, 1st, 2nd, 3rd, 4th printing, including corrections and changes issued by the AMA prior to May 16, 2000. PART V: TREATING DOCTOR'S AGREEMENT OR DISAGREEMENT WITH ANOTHER DOCTOR'S CERTIFICATION | 18. If the employee has reached MMI, indica "Impairment" means any anatomic or funct permanent. The finding that impaired exists means able injury, based upon competent of the subjective symptoms perceived by the employee does not have an able of the certify that the employee has permanent determined in accordance with the requirements involved in the calculation of the impairment ratin. | ional abnormality or loss existing after MMI that ust be made based upon objective clinical or lab jective medical evidence that is independently or oyee. By permanent impairment as a result of the compe impairment as a result of the compensable injurt of the Texas Workers' Compensation Act and g assigned using the following edition of the <u>Guid</u> | results from a compensable injury and is reasonably presumed to be pratory findings meaning a medical finding of impairment resulting from a polirmable by a doctor, including a designated doctor, without reliance on an analysis of the injury or the amount of permanent impairment is %, which was commission Rules. The attached narrative provides documentation |
| 18. Treating Doctor's Name and Degree 22. | | | prior to May 16, 2000. |
| 22. I AGREE / I DISAGREE with the certifying doctor's certification of MMI. 20. Treating Doctor's License Number and Jurisdiction I AGREE / I DISAGREE with the certifying doctor's finding of no impairment. 21. Treating Doctor's Phone & Fax #8 (Ph) (Fax) I AGREE / I DISAGREE with the impairment rating assigned by the certifying doctor. 24. I understand that making a misrepresentation about a workers' compensation claim is e crime that can result in fines and/or imprisonment Signature of Treating Doctor: Date: NOTE: With few exceptions, you are entitled by law to know, review, and correct information that DWC collects on its forms about you. For more information, call our Open Records section at 512-804-4437. NOTA: Usted tiene derencho por ley de saber, revisar y corregir información que la División ha recogido en sus formularios con algunas exepciones. Para mayor información llame a la sección de archivo abierto "Open Records" at teléfono 512-804-4437. Date Stamp | PART V: TREATING DOCTOR'S ACREE | MENT OR DISAGREEMENT WITH ANOTH | ER DOCTOR'S CERTIFICATION |
| 20. Treating Doctor's License Number and Jurisdiction I AGREE I DISAGREE with the certifying doctor's finding of no impairment. 21. Treating Doctor's Phone & Fax #8 (Ph) (Fax) I AGREE I DISAGREE with the impairment rating assigned by the certifying doctor. 24. I understand that making a misrepresentation about a workers' compensation claim is e crime that can result in fines and/or imprisonment Signature of Treating Doctor: Date: Date: NOTE: With few exceptions, you are entitled by law to know, review, and correct information that DWC collects on its forms about you. For more information, call our Open Records section at 512-804-4437. NOTA: Usted tiene derencho por ley de saber, revisar y corregir información que la División ha recogido en sus formularios con algunas exepciones. Para mayor información llame a la sección de archivo abierto "Open Records" at teléfono 512-804-4437. Date Stamp | | | EN DOBTONO GENTINGATION |
| I DISAGREE with the certifying doctor's finding of no impairment. 21. Treating Doctor's Phone & Fax #s I DISAGREE with the impairment rating assigned by the certifying doctor. 24. I understand that making a misrepresentation about a workers' compensation claim is e crime that can result in fines and/or imprisonment Signature of Treating Doctor: | | I AGREE / I DISAGREE with the | certifying doctor's certification of MMI, |
| (Ph) (Fax) I AGREE / I DISAGREE with the impairment rating assigned by the certifying doctor. 24. I understand that making a misrepresentation about a workers' compensation claim is e crime that can result in fines and/or imprisonment Signature of Treating Doctor: Date: NOTE: With few exceptions, you are entitled by law to know, review, and correct information that DWC collects on its forms about you. For more information, call our Open Records section at 512-804-4437. NOTA: Usted tiene derencho por ley de saber, revisar y corregir información que la División ha recogido en sus formularios con algunas exepciones. Para mayor información llame a la sección de archivo abierto "Open Records" at teléfono 512-804-4437. Date Stamp | 20. Treating Doctor's License Number and Jurisdiction | ☐ I AGREE / ☐ I DISAGREE with the | certifying doctor's finding of no impairment. |
| 24. I understand that making a misrepresentation about a workers' compensation claim is a crime that can result in fines and/or imprisonment Signature of Treating Doctor: Date: NOTE: With few exceptions, you are entitled by law to know, review, and correct information that DWC collects on its forms about you. For more information, call our Open Records section at 512-804-4437. NOTA: Usted tiene derencho por ley de saber, revisar y corregir información que la División ha recogido en sus formularios con algunas exepciones. Para mayor información llame a la sección de archivo abierto "Open Records" at teléfono 512-804-4437. Date Slamp | <u> </u> | I AGREE / I DISAGREE with the | impairment rating assigned by the certificing doctor |
| NOTE: With few exceptions, you are entitled by law to know, review, and correct information that DWC collects on its forms about you. For more information, call our Open Records section at 512-804-4437. NOTA: Usted tiene derencho por ley de saber, revisar y corregir información que la División ha recogido en sus formularios con algunas exepciones. Para mayor información llame a la sección de archivo abierto "Open Records" al teléfono 512-804-4437. Oate Stamp | | | |
| NOTE: With few exceptions, you are entitled by law to know, review, and correct information that DWC collects on its forms about you. For more information, call our Open Records section at 512-804-4437. NOTA: Usted tiene derencho por ley de saber, revisar y corregir información que la División ha recogido en sus formularios con algunas exepciones. Para mayor información llame a la sección de archivo abierto "Open Records" al teléfono 512-804-4437. Oate Stamp | Signature of Treating Doctor | | Date: |
| For more information, call our Open Records section at 512-804-4437. NOTA: Usted tiene derencho por ley de saber, revisar y corregir información que la División ha recogido en sus formularios con algunas exepciones. Para mayor información llame a la sección de archivo abierto "Open Records" at teléfono 512-804-4437. Date Stamp | | ··· <u>··</u> | |
| exepciones. Para mayor información llame a la sección de archivo abierto "Open Records" al teléfono 512-804-4437. Date Stamp DWC FORM-59 (Rev. 10/05) Page 1 | For more information, call our Open Record | Is section at 512-804-4437. | • |
| DWC FORM 59 (Rev. 10/05). Page 1 | exepciones. Para mayor información llame | a la sección de archivo abierto "Open R | ecords" al teléfono 512-804-4437. |
| THE PROOF OF MORKERS' COMPENSATION | DWC FORM-69 (Rev. 10/05) Page 1 | | Date Stamp Division of Workers' Compensation |

Patient:

Hessom, Kirk C

DX:

Insect Bite, Nonvenomous Of Elbow, Forearm, And Wrist, Withoutmention

Physician:

Sanchez, MD, John M

Location:

CMC - Houston Hobby

The patient's injury occurred on 07/16/2007. The patient stated, I was at work when I got bit by a spider.

The patient was evaluated on 07/17/2007.

Date of MMI 07/17/2007.

The treatment plan included: Regular activity.

Findings of the certifying examination/explanation of performed analysis are 913.4, Insect Bite, Nonvenomous Of Elbow, Forearm, And Wrist, Withoutmention

Lab and X-Ray tests: None

Description of the results of the most recent clinical evaluation of the employee

Current Clinical Status: On the most recent evaluation, the exam was normal. The patient was returned to regular activity and released from care on 07/17/2007.

Diagnosis and clinical findings of permanent impairment: Employee does not have any permanent impairment as a result of the compensable injury.

AMA Guides to the Evaluation of Permanent Impairment Edition: None

CES Environmental Marlin Moser 4904 Griggs Rd HOUSTON, TX 77021 AUG 0 1 2007

1500

HEALTH INSURANCE CLAIM FORM

PPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/03

| PICA . | <u> </u> | | | | PICA TT |
|--|---------------------------|--|------------------------------------|---|--|
| 1. MEDICARE MEDICAID TRICARE CHAMPU | CHAMPV | A GROUP | FECA OTHER | R 1A. INSURED'S I.D. NUMBER | (FOR PROGRAM IN ITEM 1) |
| (Medicare #) (Medicaid #) (Sponsor's SS | | | (SSN) X (ID) | 448-86-2987 | |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) | | 3. PATIENT'S BIRTH DATE | SEX | 4. INSURED'S NAME (Last Name, First Na | me, Middle Initial) |
| Hessom, Kirk C | | (b) (4) | X F | CES Environmen | tal |
| 5. PATIENT'S ADDRESS (No Street) | | 6. PATIENT'S RELATIONSHIP TO IN | VISURED | 7. INSURED'S ADDRESS (No Street) | |
| (b) (4) | | Self Spouse Child | Other | 4904 Griggs Rd | |
| CITY | STATE | 8. PATIENT STATUS | <u> </u> | ату | STATE |
| (b) (4) | TX | Single Married | Other | HOUSTON | тx |
| ZIP CODE TELEPHONE (includ | Area Code) | 1 | | ZIP CODE | TELEPHONE (INCLUDE AREA CODE) |
| 6) (4) | | Employed Full-Time Student | Part-Time Student | 77021 | 936 632-1925 |
| У. ОТНЕМ INSUREDS INAME (LASTINAME, HIST NAME, MIDDIE IIIIIS | u) | 10. PATIENT'S CONDITION RELAT | ED TO: | 11. INSURED'S POLICY GROUP OR FECA | NUMBER |
| N/A | | | | | |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER | | a. EMPLOYMENT? (CURRENT OR | PREVIOUS) | a. INSURED'S DATE OF BIRTH | SEX |
| N ₄ /A | | X YES | NO | N / A | M F |
| b. OTHER INSURED'S DATE OF BIRTH SE | | b. AUTO ACCIDENT? | PLACE (State) | b. EMPLOYER'S NAME OF SCHOOL NAM | nE |
| N / A | F | YES | NO | N/A | |
| C. EMPIPOYER'S NAME OR SCHOOL NAME | | c. OTHER ACCIDENT? | | c. INSUPANCE PLAN NAME OR PROGRAM | A NAME |
| N / A | | YES | МО | N/A | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | 10d. RESERVED FOR LOCAL USE | | d. IS THERE ANOTHER HEALTH BENEFIT | PLAN? |
| N / A | | <u> </u> | *** | YES NO | If YES, return to and complete items 9e-d. |
| READ BACK OF FORM BEFORE 12. PATIENT'S OR AUTHORIZED PERSON'S BIGNATURE. I auth | | | v to process this dair- | 13. INSURED'S OR AUTHORIZED PERSO benefits to the undersigned physician | NS SIGNATURE 1 authorize payment of medical n or supplier for services described below. |
| laiso request payment of government benefits either to mys | elfor to the party who ac | cepts assignment below. | у со ріссова віїз стаїт. | | |
| CTCNAMING ON SILI | a | 37 / 3 | | ET CON A II | URE ON FILE |
| SIGNATURE ON FILE | 3 | DATE N / A | | SIGNED STGRAT | ORE ON FILE |
| 14 DATE OF CURRENT ILLNESS (FIRST SYMM DD YY INJURY (ACCIDENT) O | | F PATIENT HAS HAD SAME OR SIMIL BIVE FIRST DATE MM ; DO | AR ILLNESS, YY | 18. DATES PATIENT UNABLE TO WORK I | MM : DD : YY |
| 07 16 2007 INJURY (ACCIDENT) OF PREGNANCY (LMP) | 170 | O7: 16 | 2007 | FROM N A DD YY 18. HOSPITALIZATION DATES RELATED 1 | TO N / A |
| 17. NAME OF REPENSING PHYSICIAN ON OTHER SCORCE | 17a. | NPI | | FROM ID YY | MM DD YY |
| 19. RESERVED FOR LOCAL USE | | NO | | N / A | N / A |
| 19. NEDERYED FAN LOUAL USE | | | | | \$ CHARGES |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE IT | LIE 1 2 2 OP 4 TO ITEM | 24E BY LINE | | YES NG 22. MEDICAID RESUBMISSION | |
| | LWS 1,2,3 ON 4 TO TIEM | |] | CODE N / A | ORIGINAL REF. NO. N / A |
| 1. 913.4 | 3 | · <u>L</u> . | 4 | 23. PRIOR AUTHORIZATION NUMBER | |
| | | | · | N / A | |
| 2 | 4 | | | | |
| 24. A DATE(8) OF SERVICE B | 'c' PROCEDI | D URES, SERVICES OR SUPPLIES | E | F 'G ' | H I J SOT ID. RENDERING |
| FROM TO of MM DD YYYY MM DD YYYY Service | Expli EMG CPT/HCPCS | ain Unusual Circumstances) MODIFIER | DIAGNOSIS POINTER | \$ CHARGES OR F | amity QUAL PROMDER ID. # |
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| Immunization adminis 07:16:07:07:16:07:11 | | | 1 | 224 88 1 | 0B MDH0784 |
| Level 4 New Complex | 1 1 | 041 ; ; | 1 1 | 224 88 1 | NPI 1578605648 OB MDH0784 |
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| Required report char | | | | + - + | OB MDH0784 |
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| | 1 1 | | | | NPI |
| | | that the same of t | | | |
| | 1 ! 1 1 | | | | NPI |
| 25. FEDERAL TAX I.D. NUMBÉR SSN EIN | 26. PATIENT'S ACCOL | INT NG. 27.ACCEI | PT ASSIGNMENT? dalms, see back) | 28. TOTAL CHARGES 29. | ANOUNT PAID . 30, BALANCE DUE |
| 752014828 X | 101-0041 | | NC | s 320 35 s | 0 00 s 320 35 |
| 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDRINTALS | 32. NAME AND ADDRE | ESS OF FACILITY WHERE SERVICES or than home or office) | WERE | 33. PHYSICIAN'S, SUPPLIER'S BILLING N & PHONE #. | AME, ADDRESS, ZIP CODE |
| (I certify that the statements on the reverse apply to this bill and are made a part thereof.) | 1 | ouston I-10 Eas | st | Occupational He | (800)733-7098 alth Centers |
| | Concenti | ra Medical Cent | | of the Southwes | t, P.A. |
| Tohn M Comph 1m | 10909 I- | -10 East Frwy | | PO Box 9005 Addison, TX 750 | 01-9005 |
| John M Sanchez, MD 07/27/2007 | | <u>TX 77029</u> | | | |
| 07/27/2007 SIGNED DATE | 14674618 | 371 b | | a. (1.37.1) | ^b MDH0784 |





Houston, TX 77029 (713) 973-7943 10909 I-10 East Frwy

Patient: Soc. Sec. #

Hessom, Kirk Date of Birth: Service Location:

Service Date: Injury Date: **Employer:** 07/16/2007 07/16/2007

Age: 36 CMC - Houston I-10 East CES Environmental 4904 Griggs Rd

Service ID #:

42820729

Claim #:

HOUSTON, TX 77021

Dictator:

John M Sanchez, MD

913 4 Diagnosis:

Insect Bite, Nonvenomous Of Elbow, Forearm, And Wrist, Withoutmention

Notes: CHIEF COMPLAINT:

Patient is a 36 year old male employee of CES Environmental who complains a

HISTORY OF PRESENT ILLNESS:

The bite is located on the right forearm. Denies bleeding.

SOCIAL HISTORY: Noncontributory based upon review of comprehensive questionnaire.

FAMILY HISTORY: Noncontributory based upon review of comprehensive questionnaire.

PAST MEDICAL HISTORY: PMH: Noncontributory.

Current Medications: None.

Allergies: Denies known allergies. Immunizations: Not up to date.

ROS: ROS:GENERAL: No chills. No fever. Denies weakness.SKIN: No lesions. Denies rash.HEENT: No blurred vision. No headache. Denies hearing loss.CHEST: No cough. Denies chest pain. Denies shortness of breath.CARDIOVASCULAR: Denies palpitations.ABDOMEN: No abdominal pain. No constipation. No diarrhea. Denies nausea. Denies vomiting.HEMATOLOGIC No anemia. No easy bruisability.PERIPHERAL VASCULAR: Denies thrombophlebitis. Denies varicose veins.MUSCULOSKELETAL: See HPI.

PE:

VITAL SIGNS: See nurses notes. CHEST: Lungs clear to auscultation.

CARDIOVASCULAR: Normal S1, S2. No murmurs or gallops.

Area of redness marked on the right forearm.

ASSESSMENT: Spider bite. Depomedrol 40 IM, Benadryl 25 mg q 8 hours prn, light duty. Follow up tomorrow. To ER for any SOB or change in the condition of the arm.

PLAN: Above.

Diagnosis, treatment plan and expectations were discussed with the patient. The signs and symptoms of infection were discussed with the patient. The patient was instructed to RTC or go to the ER for any signs of infection. The patient expressed understanding of the instructions.

bout his arm which was injured on 07/16/2007 9:30:00 AM.

PATIENT STATEMENT:

Patient states: "Patient was at work and bitten by a spider "

Vital Signs: BP: 122/88. P: 72. R: 16. T: 98.1 degrees F orally.

Dictated But Not Read

Dictated By: John M Sanchez, MD

Dictated On: Jul 16 2007 12:05PM

Printed Date: 07/27/2007

Page: 1



Transcription

10909 I-10 East Frwy

<u>Hessom, Kirk</u> C

Houston, TX 77029 (713) 973-7943

Patient:

Soc. Sec. #

Date of Birth: Service Location:

Service ID #:

42820729

Age: 36 CMC - Houston I-10 East

Injury Date: Employer:

Service Date:

07/16/2007 07/16/2007

CES Environmental

4904 Griggs Rd

Claim #:

Dictator:

John M Sanchez, MD

Diagnosis:

913.4

HOUSTON, TX 77021

Insect Bite, Nonvenomous Of Elbow, Forearm, And Wrist, Withoutmention

Notes: Time:11:49 AM by: N L.

Dictated But Not Read

Dictated By: John M Sanchez, MD

Dictated On: Jul 16 2007 12:05PM

Printed Date: 07/27/2007

Page: 2

Employee - You are required to report your injury to your employer within 30 days if your employer has workers' compensation insurance. You have the right to free assistance from the Texas Workers' Compensation Commission and may be entitled to certain medical and income benefits. For further information call your local Commission field office or 1(800)-252-7031.



Trabajador - Es necesario que ustod reporte su tesión a su empleador dentro de 30 días a partir del día en que se lesiono, si su empleador tiene seguro de compensación para trabajadores, la Comisión Tejana de Compensación para Trabajadores le ofrece asistencia gratula, también puede que usted tenga derecho a ciertos beneficios médicos y monetarios. Para mayor información llame a la oficina local de la Comisión 1-800-252-7031.

TEXAS WORKERS' COMPENSATION WORK STATUS REPORT

| | TEXAS WC | KNEK | 3 COMPENSA | HON WORK 3 | HAL | US KEPUK I | |
|--|---|-----------------------------|---|---|---------------|--|-------------------------------|
| PART I: GENER | RAL INFORMATIO | N K I | loctor's Name and Degree John M Sanchez, MD | | (for tran | nsmission purpose only) | Date Being Sent 07/27/2007 |
| Injured Employee's Nam Kirk C Hessom | e | | 6. Clinic/Facility Name CMC - Houston I-10 East | | | oloyer's Name S Environmental | |
| 2. Date of Injury 07/16/2007 | 3. Social Security Number | (| linic/Facility/Doctor Phone & Fa 713)973-7943 | (713)973-7947 | (713 | nployer's Fax # or Email Address (if 3)676-1676 | known) |
| Employee's Description of Patient states: "Patient spider" | or injury/Accident of was at work and bitter | by a 1 | linic/Facility/Doctor Address (S | | CES | surance Carrier S Environmental | |
| | | City | State Duston, TX 77029 | Zip | | rrier's Fax# or Ernail Address (if kr 3)676-1676 | |
| | | | (FULLY COMPLETE ON | | ED DATE | ES AND DESCRIPTION IN 13 | (c) AS APPLICABLE) |
| (a) will allow the en | nployee to return to wo | rk asof | (date) without | restrictions. | i in PAR | ₹T III which are | |
| expected to last the (c) has prevented a | rough <u>07/30/2007</u> (date). Ind still prevents the emplo | yee from I | returning to work as of this injury prevents the | (date) and is | expecte | d to continue | |
| PART III: ACTIV | /ITY RESTRICTION | DNS* (or | NLY COMPLETE IF BOX 1 | 3(b) IS CHECKED) | | | |
| | | , I C | | | | 40 MICC DECEDICATIONS (SE | |
| 14. POSTURE RESTRIC | CITONIS (IT any): | | 17. MOTION RESTRICT | IONS (If any): | [] | 19. MISC. RESTRICTIONS (if | |
| Max Hours per day: Standing | 0 2 4 6 8 Othe | ų | Max Hours per day: Walking | 0 2 4 6 8 Other | r | Max hours per day of worSit/Stretch breaks of | |
| Sitting | | _ | Climbing stairs/Ladders | | - { | Must wear splint/cast at | wark |
| Kneeling/Squatting | | _ | Grasping/Squeezing | | _ } ; | Must use crutches at all t | |
| Bending/Stooping Pushing/Pulling | 00000 | | Wrist flexion/extension | | - | No driving/operating heav Can only drive automatic | |
| Twisting | | _ | Reaching Overhead Reaching | | - | No work / | |
| Other: | | | Keyboarding | | | in extreme hot/cold en | • |
| 15. RESTRICTIONS SP | ECIFIC TO (if applicable |): | Other: | | _ | at heights or on scaffo | olding |
| L Hand / Wrist | R Hand / Wrist | | 18. LIFT/CARRY REST | RICTIONS (if any): | | X Must keep wound | : |
| L Arm | | Neck Back | May not lift/carry objection for more than | ects more than lbs hours per day | | _ | Clean & Dry |
| L Foot/Ankle | R Foot/Ankle | Dack | May not perform any | lifting/carrying | | No skin contact with: Dressing changes neces: | |
| Other: | | | Other: | | _ | No Running | saly at Work |
| 16. OTHER RESTRICT | ONS (if any): | uneration a | nu machines | | | 20. MEDICATION RESTRICTION | , |
| no anying, no workii | ig around electicity, no t | peraung a | ny mactimes, | | | | |
| * These restrictions are | e based on the doctor's | best under | standing of the employee | 's essential job functions | . If a | Medication may make dro | |
| particular restriction do available, the patient sh as well as at work | es not apply, it should be ould be considered to be | e disregard off work. No | standing of the employee ed. If modified duty that r ote - these restrictions sho | meets these restrictions in uld be followed outside of | s not work | (Possible safety/driving is | sues) |
| PART IV: TREA | TMENT/FOLLOW | | POINTMENT INFO | DRMATION. | | | |
| | | | | · · · · · | | | |
| 21. Work Injury Diag 913.4 Insect Bite, Non- Forearm, And Wrist, W | venomous Of Elbow. | | cted Follow-up Service ation by the treating doctor | | | 07/17/2007 (dat | e) at <u>8:00AM</u> am/pm |
| Porearm, And Wrist, W | unoumention | | | | | on (dat | |
| | ! | | | | | on(date | |
| | : | | | | | no further medical care is antic | |
| Date / Time of Visit | EMPLOYEE'S SIGNATU | | DOCTOR'S SIGNAT | } <i>i</i> ⊊7 | isit Type: | Role of Doctor Designated doctor | X Treating doctor |
| 07/16/2007 11:26AM Discharge Time 07/16/2007 12:52PM | | en Ci | EU OF TREATING PHYS | iician signature 🖺 | Follow- | | Consulting doctor |
| | | II IR PRE I | | PICAL DIRECTOR | | | |
| | | | | | | | |
| | 1 (REIII 1 | | | :: : : | | | |



C E S ENVIRONMENTAL SERVICES I

4904 GRIGGS RD HOUSTON, TX 77021-3208

FOR FAST AND EASY CLAIM REPORTING, FILE YOUR CLAIMS ON-LINE AT www.texasmutual.com

Texas Mutual Insurance Company has received notice of an injury that occurred on 07/16/2007 to HESSOM, KIRK C.

The carrier claim number assigned to this claim is 99H0000497534.

FOR POLICYHOLDERS WHO HAVE SELECTED THE NETWORK OPTION ONLY - If you have network coverage at the time of the injury, you are required to obtain a second Employee Acknowledgement of Workers' Compensation Network Form. Please submit a copy of the second acknowledgement form to Texas Mutual. If you wish to speak to a TMI representative please call 1-800-859-5995. You may also refer to www.texasmutual.com for more information.

To review specific claim information, you may use our online system available through our website, http://www.texasmutual.com. If you do not have a Texas Mutual on-line services ID, please call Texas Mutual at (800) 859-5995 to obtain an ID.

Please refer to the Texas Department of Insurance, Division of Workers' Compensation at http://www.tdi.state.tx.us for additional information including employer and employee rights and responsibilities.

Texas Mutual has contracted with ScripNet to ensure your employees obtain the prescription drugs needed to treat their work related injury. ScripNet is available seven days a week at 1-888-880-8562 to obtain a list of network pharmacies in your area or log on to http://www.scripnet.com.

For your records, below is a copy of the information used to establish this claim. Any additional claim, payment or employee wage information can be can be faxed to us at (512) 224-3889.

Policy Number: TSF0001086044 Employee Name: KIRK HES Social Security Number Date of Birth Marital Status. Unknown Gender: M Dependents: Spoken Language: English Home Phone: ()
Employee Address 1: (b) (4) Employee Address 2: City/State/Zip: HOUSTON, TX 77087 County: HARRIS Email Address: Hire Date: / /0 Hire State: Partner/Officer/Owner?: Occupation: Rate of Pay: Frequency of Payment: Work Week: Last Pay Check: Check was for:

JUL 3 0 2007

Texas Mutual Insurance Company 6210 E Highway 290, Austin, Texas 78723-1098 512.322.3800 /800.859.5995 / fax 877.404.7999 / www.texasmutual.com

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Check Period Start Date: / /0
Check Period End Date:
Is Employer planning to continue Employee's salary ?: If Yes, Gross Amount of Continued Salary: 000000 Attorney/Representation ?: N
Date of Injury: 07/16/2007
Time of Injury: 00:00:00
Date Lost Time Began: 00:00:00
Date Reported to Employer: 07/16/2007
Employee Working Regular Job:
Return to Work Date: / /0
Body Part: UNKNOWN/ NOT REPORTED
Nature: UNKNOWN/NOT REPORTED
Cause: MISC. CAUSES-OTHER MISCELLANEOUS, NOC Description: CLAIM CREATED FROM DWC-66.
Injury Address:
City/State/Zip: -
County:
Witness Name:
Witness Phone:
Fatality?: N
Physician Name: JOHN M SANCHEZ MD
Physician Phone: (713) 973-7943
Physician Email:
Tax ID Number: 76-0592985
Customer Location ID:
Business Name: C E S ENVIRONMENTAL SERVICES I
Business Address 1: 4904 CRIGGS RD
Business Address 2:
City/State/Zip: HOUSTON TX 77021-3208
Employers Phone: (713) 676-1460
Supervisor's Name:
Supervisor's Phone:
Supv.Email:
Preparer's Name:
Preparer's Phone: ( ) -
Prep Email:
```

Albert Hall 8-13-07

EPAHO043000033

CES Environmental Services, Inc.

INCIDENT REPORT Near Miss Accident DATE OF INCIDENT: 9-13-67 TIME: RESULT OF INCIDENT: For Accidents check all that apply, for Near Misses ONLY 6 & 7 may be checked. 2) EXPLOSION 3) VEQUIPMENT DAMAGE 4) PROPERTY DAMAGE 5) PRODUCT LOSS 6) PRODUCTION LOSS 7) EMPLOYEE ENDANGERMENT 8) OTHER PERSON(S) DIRECTLY INVOLVED: EXACT LOCATION WHERE INCIDENT OCCURRED: LAKE Charles Bridge on the fast DESCRIBE FULLY HOW INCIDENT OCCURRED: I was Kolling East on I-10, Borne for mississ ippi The Coner of my right eye this Con Approching the interstant of hookinmingon on helt side I look in menion on helt side I hook in menion on helt this find The Can take in front of me it hook at loft side and AT This find The Can take in front of me, I had to go to the misht side to ite can what what unsafe acts/conditions lead to incident?: The variety of the car did not RECOMMENDATIONS TO PREVENT REOCCURRENCE: Change the way that intrance Ketrup of Can to get un I-10 E at the base of the Bridge. COMMENTS: I did All I could do in a Split second.

Prepared by (Print): Will T No C Title: Driver Initials: H. M. Approved by (Print): Robbeh Manager Initials: MT

Safety Representative Notified (Name): Prophabut Thange

Name:

Rev 8.01

WITNESSES (Print):
Name:

Name:

ecoes the penson during just stop or slowed down nd Right in front of inc. I had 25,000 tBr. of product n tout slashing around in troiten. If I had not went to he right side of car. I would have hit in the but the on Riek end of car i I f I had went to bett side I would have hit a pick up truck a So I did the bust I could do, the Koep From Witting them in the ROUR, and Chancing that Their gos TANK Blower not where the trailer struck the the tell that The Cash was very slow or stoped kight in front et me. 4 throught she was soing to stop, on Yeal the Right of hak Charles Bridge As you see I got Ever Buids C half of my two len poss The can Rober Contest. Bridge Buce so she was Realy mouns slow getting on I-10 East Their was A The distance YellD Eigh for The can Between The care and me in The Thouse was Abe on 10'to 15' ha force I made my Books . Alle Dansey water toel pod Trench. EPAHO0430000 Rønnie Mordes Accident 8-29-2007

EPAHO043000036

CES Environmental Services, Inc.

4904 Griggs Road Houston, TX 77021 Phone: (713) 676-1460 Fax: (713) 676-1676

Fax

| To: Latonica N. Ray | From: | Prabhakar R. Thangudu |
|--|--------|-----------------------|
| Fax: 512-224-3889 | Pages: | Mobile: (b) (4) |
| Phone: | Date: | 8-79-07 |
| Ms. Ray: RE: Ronnie More SS# (5) (4) | les | |
| DWC Form | 1_ | |
| Please coll if | you n | eed additional |
| information. | Than | nk/ |
| | Pak | hah |

| Send the specified copies to your Workers' Compensation Insurance Carrier and the injured employee. | |
|---|--|
| *Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, Unless the Division specifically requests a direct filling. | CLAIM# |
| | |
| | CARRIER'S CLAIM# |
| EMPLOYERS FIRST REPOR | RT OF INJURY OR ILLNESS |
| 1. Name (Last, First, M.I.) | 15. Date of Injury (m-d-y) 16. Time of Injury 17. Date Lost Time Began |
| MORALES KONNIE L. | 08-29-2007 10:15 am pm (m-d-y) N-/A- |
| 3. Social Security Number 4. Home Phone 5. Date of 6irth (m-d-y) (b) (4) (D) (4) | 18. Nature of Injury Causto 19. Part of Body Injured or Exposed* NSKIN VOCAL APPLA |
| b Does the Employee Speak English? If No, Specify Language | 20 How and Why Injury/Illness Occurred* |
| YES ME NO [] | Caustic hose broke loose spraying contents near vocal area |
| 7. Race 8. Ethnicity Hierania M | |
| 8. Ethnicity Hispanic Black Asian Native American Other Other | 21. Was employee doing his YES Tregular job? NO I State Location of Injury (steirs, dock, etc.)* |
| 9 Mailing Address Street or P.O. Box | 23. Address Where Injury or Exposure Occurred Name of business if incident |
| (b) (4) | occurred on a business site 4904 691.095 Road |
| (b) (4) | Street or P.O. Box County |
| | |
| 10. Marital Status Married Widowed Separated Single Divorced Divorced Div | City HONSTON State Zip Code 77021 |
| 11. Number of Dependent Children 12. Spouse's Name | 24. Cause of (njury(fall, tool, machine, etc.)* |
| -O- MARIAM | hase broke loose |
| 13. Doctor's Name | 25. List Witnesses Rolando Soto |
| 14. Doctor's Mailing Address (Street or P.O.Box) | 26. Return to work 27. Did employee 28. Supervisor's 29. Date Reported |
| (| date/or expected die? Name (m-d-y) |
| City State Zip Code | Ben an |
| | N/A YES NOW Neathers 08-29-07 |
| | 03-21-01 |
| 30. Date of Hire (m-d-y) 31. Was employee hired or recruited in Texas? | 32. Length of Service in Current Position 33. Length of Service in Occupation |
| (b) (4) YES (2) NO (1) | Months Z Years O Months D Years 4 |
| 34. Employee Payroll Classification Code 35. Occupation of Injured W | orker |
| HELP | |
| 36. Rate of Pay at this Job 37. Full Work Week is: | 36. Last Paycheck was: 39. Is employee an Owner, Partner, or Corporate Officer? |
| Hourly \$ A Weekly 40 Hours 5 Days | \$702 for 2 Hours or Days YES NO D |
| 40. Name and Title of Person Completing Form | 41. Name of Business |
| Brabbakar R. Thonguan | CES Environmental Services, Inc. |
| 42. Business Mailing Address and Telephone Number | 43. Business Location (if different from mailing address) |
| Street or P.O. Box 4904 G9-iggs Road (713) 676-1460 | Number and Street |
| City State Zip Code | City State Zip Code |
| HOUSTON TX 77021 | |
| 44. Federal Tax Identification Number 76-0592985 45. Primary North American Industry Classific Code: (6 digit) 1542 | ation System 46. Specific NAICS Code 47. Texas Comptroller Taxpayer No. (6 digit) 562ZI9 176059Z9854 |
| 48. Workers' Compensation Insurance Company | 49. Policy Number |
| Texas Mutual | TSF 0001086044 |
| 50. Did you request accident prevention services in past 12 months? | |
| YES ☑ NO ☐ If yes, did you receive them? YES ☑ NO☐ 51. Signature and Title (READ/ASTRUCTIONS ON INSTRUCTION SHEET BEFORE SIG | NING) |
| X Labbank Lauge | Date 8-29-2007 |
| | |



(b) (4)

Employee Acknowledgment of Workers' Compensation Network

I have received information that tells me how to get health care under my employer's workers' compensation insurance.

If I am hurt on the job and live in a service area described in this information, Lunderstand that:

- 1. I must choose a treating doctor from the list of doctors in the network. Or, I may ask my HMO primary care physician to agree to serve as my treating doctor. If I select my HMO primary care physician as my treating doctor. I will call Texas Mutual at (800) 859-5995, extension 2880 to notify them of my choice.
- 2. I must go to my treating doctor for all health care for my injury. If I need a specialist, my treating doctor will refer me. If I need emergency care, I may go anywhere.
- 3. The insurance carrier will pay the treating doctor and other network providers.
- 4. I might have to pay the bill if I get health care from someone other than a network doctor without network approval.
- 5. Making a false or fraudulent workers' compensation claim is a crime that may result in fines and or imprisonment.

| Clonic storales | 6/26/07 |
|---|----------------|
| Signature | Date |
| Rome Morales | |
| Printed Name | |
| (b) (4) | |
| Street Address | |
| (b) (4) | |
| City | State Zip Code |
| Name of Employer: CES Environmental | Services. Inc. |
| Name of Network: Texas Star Network _{SM} | |
| Network service areas are subject to chang Call (800) 381-8067 if you need a network t | |
| Please indicate whether this is the: | |
| Initial Employee Notification | |
| $oxtimes$ Injury Notification (Date of Injury: $oldsymbol{	ilde{OS}}$. | 129 12007) |

DO NOT RETURN THIS FORM TO TEXAS MUTUAL INSURANCE COMPANY UNLESS REQUESTED

Employee Notice of Network Requirements – 03/06

Page 8 of 8

******* -IND. XMT JOURNAL- ********* DATE AUG-29-2007 **** TIME 14:43 *******

DATE/TIME = AUG-29-2007 14:40

JOURNAL No. = 115

COMM. RESULT = OK

PAGE(S) = 003

DURATION = 00:00:28

FILE No. = 036

MODE = MEMORY TRANSMISSION

DESTINATION = 15122243889

RECEIVED ID =

RESOLUTION = STD

-CES Environmental Svcs. -

***** DP-3030 ***********

_ **** _

7137488664- ******

To: Dan Bowman 7136761676

Employee - You are required to report your injury to your employer within 30 days if your employer has workers compensation insurance. You have the right to free assistance from the Texas Vorkers Compensation Commission and may be entitled to cerain medical and income benefits. For further information call your local Commission field office or 1(800) 252-7031.



Trabajador. Es necesario que usted reporte su lesión a su empleador dentro de 30 días a partir del día en que se lesionó, si su empleador tiene seguro de compensación para trabajadores. la Comisión Tejana de Compensación para Trabajadores le ofrece asistencia gratuita, también puede que usted tenga derecho a cierce beneficios médicos y monetarios. Para mayor información llame a la oficina local de la Comisión 1-800-252-7031.

| TEXAS WORK | ERS' COMPENSATION WORK STAT | rus report |
|---|--|--|
| PART I: GENERAL INFORMATION | 5. Doctor's Name and Degree John M. Sanchez, MD | (for transmission Date Being Sent purposes only) |
| Irjured Employee's Name | 6. Crinic/Facility Name | 9. Employer's Name |
| Ronnie L. Morales | CMC - Houston I-10 East | CES Environmental |
| Date of Injury 3. Social Security Number | 7. Clinic/Facility/Doctor Phone & Fax | 10. Employer's Fax # or Email Address (if known) |
| 08/29/2007 (b) (4) | (713)973-7943 (713)973-7947 | (713)676-1676 |
| · · · · · · · · · · · · · · | Clinic/Facility/Doctor Address (street address) | 11, Insurance Carner |
| Patient states:"I was working a hose busted and I got chemical on my face and neck" | 10909 I-10 East Frwy | Texas Mutual Insurance Company |
| <u> </u> | City State Zip Houston TX 77 0 29 | 12. Carrier's Fax # or Email Address (if known) (512)322-3889 |
| PART II: WORK STATUS INFORMATION | V (FULLY COMPLETE ONE INCLUDING ESTIMATED DATES | AND DESCRIPTION IN 13(c) AS APPLICABLE) |
| (b) will allow the employee to return to we expected to last through (c) has prevented and still prevents the empth of through (date). The following the following through (date). | ork as of(date) without restrictions. ork as of(date) with the restrictions (date). ployee from returning to work as of wing describes how this injury prevents the employe | |
| PART III: ACTIVITY RESTRICTIONS* (F | REQUIRED IF BOX 13(b) IS CHECKED) | |
| 14. POSTURE RESTRICTIONS (if any) : | 17. MOTION RESTRICTIONS (if any): | 19. MISC. RESTRICTIONS (if any): |
| , ,, | ` " | Max hours per day of work: |
| Max Hours per day: 0 2 4 6 8 Other | Max Hours per day: 0 2 4 6 8 Other | |
| Standing | Walking LJLLL | Sit/Stretch breaks ofper |
| Sitting | Climbing stairs/ladders | Must wear splint/cast at work |
| Kneeling/Squatting | Grasping/Squeezing | Must use crutches at all times |
| | | |
| Bending/Stooping | Wrist flexion/extension | No driving/operating heavy equipment |
| Pushing/Pulling | Reaching | Can only drive automatic transmission |
| Twisting | Overhead Reaching | ☐ No work/ ☐ hours/day work: |
| | | |
| Other: | Keyboarding | in extreme hot/cold environments |
| 15. RESTRICTIONS SPECIFIC TO (if applica | ble): Other: LLLL | at heights or on scaffolding |
| L Hand/Wrist R Hand/Wrist | 18. LIFT/CARRY RESTRICTIONS (if any): | Must keep |
| □L Arm □ B Arm □ Ne | eck May not lift/carry objects more thanlbs | Elevated Clean & Dry |
| | - | |
| | ck for more thanhours per day | No skin contact with: |
| L Foot/Ankle R Foot/Ankle | May not perform any lifting/carrying | Dressing changes necessary at work |
| Other: | Other: | ☐ No running |
| 16. OTHER RESTRICTIONS (if any): | | 20. MEDICATION RESTRICTIONS(if any); |
| ` . | | Must take prescription medication(s) |
| | Medicini Ned and distriction on the second | |
| | | Advised to take over-the-counter meds |
| | erstanding of the employee's essential job functions. If a particular standard the standard standard the standard standa | |
| | nodified duty that meets these restrictions is not available, the p ictions should be followed outside of work as well as at work. | safety/driving issues) |
| STIGHT DO CONTINUE TO DO ON WORK, 1900 PROSE TO SE | Ellerts Stibute of tenetrod busines of Work at Well at all Work. | |
| PART IV: TREATMENT/FOLLOW-UP AP | POINTMENT INFORMATION | |
| | Expected Follow-up Services Include: | ***** |
| 692.41 Contact dermatitis and other eczema due | Evaluation by the treating doctor on 08/31/2007 | (date) at 11:45 am am/pm |
| | Referral to/Consult withon_ | (date) at am/pm |
| <u>_</u> | Physical medicineX per week forweeks starting | ng on (date) at am/pm |
| | Special studies (list): | on (date) at am/pm |
| | None. This is the last scheduled visit for this problem. | At this time, no further medical care is anticipated |
| Date / Time of Visi EMPLOYEE'S SIGNATURE | DOCTOR'S SIGNATURE Visit Type: | ole of Doctor: X Treating doctor |
| 08/29/2007 11:42 and Discharge Time | ☑ Initial | Designated doctor Referral doctor |
| 08/29/2007 02:13 pm | ☐ Follow-⊔p | Carrier-selected RME Consulting doctor Other doctor |
| 40.50.504) 05.14 MI | | DWC-salected RME Other doctor |

DWC FORM-73 (Rev. 10/05) Page 1



DIVISION OF WORKERS' COMPENSATION

Claim Number:

Concentra Medical Centers

10909 I-10 East Frwy Houston, TX 77029 Phone: (713) 973-7943 Fax: (713) 973-7947

Service Date: 08/29/2007 Case Date: 08/29/2007

Physician Activity Status Report

Patient: Morales, Ronnie L SSN: Address: Address: Home: Ext.: Work:

Employer Location: CES Environmental

4904 Griggs Rd

Contact: Prabhakar Thangudu

Role: **DER/Primary**

Phone: (713) 676-1460

Auth. by:

HSE Manager

HOUSTON, TX 77021

(713) 676-1676 Fax:

This Visit: Time In: 11:40 am Time Out: 02:13 pm Recordable: No Visit Type: New

Treating Provider: John M. Sanchez, MD Medications:

☐ Dispensed Prescription Medication to Patient

Diagnosis: 692.41 Contact dermatitis and other eczema due to chemical expo Dispensed Over-The-Counter Prescription

■ Written Prescription given to Patient

Patient Status:

Regular Activity - Returning for follow-up visit

Return to regular duty on 08/29/2007

Remarks:

Employer Notice:

The prescribed activity recommendations are suggested guidelines to assist in the patient's treatment and rehabilitation. Your employee has been informed that the activity prescription is expected to be followed at work and away from work.

Anticipated Date of Maximum Medical Improvement: 09/11/2007 Actual Date of Maximum Medical Improvement:

© 1996 - 2007 Concentra Health Services, Inc. All Rights Reserved.

Next Visit(s):

It is essential to your recovery that you keep your scheduled appointments, but should you need to reschedule or cancel your appointment, please contact the clinic. Thank you for your cooperation.

Friday August 31, 2007 11:45 am

Provider/Facility: John M. Sanchez, MD



Date of Service: 08/29/2007 Date of Injury: 08/29/2007

Attn: Prabhakar Thangudu CES Environmental 4904 Griggs Rd HOUSTON, TX 77021

Dear Prabhakar Thangudu:

Your employee Ronnie L. Morales received treatment for a new work related injury at our CMC - Houston I-10 East clinic on 08/29/2007.

The billings for this injury care will be sent to Texas Mutual Insurance Company. Please help us provide the best care to your injured employee by filing the Employer's First Report of Injury with your carrier, if not already filed. This will ensure timely reporting and management of this workers' compensation claim.

If you have any questions or the above information is incorrect, please call our office or fax any changes to the attention of the Billing Department.

Sincerely,

CMC - Houston I-10 East Central Business Office 800-733-7098 972-458-7678 Employee - You are required to report your injury to your employer within 30 days if your employer has workers compensation insurance. You have the right to free assistance from the Texas Workers Compensation Commission and may be entitled to certain medical and income benefits. For further information call your local Commission field office or 1(800)-252-7031.



Trabajador - Es necesario que usted reporte su tesión a su empleador dentro de 30 dias a partir del día en que se lesionó, si su empleador tiene seguro de compensación para trabajadores. la Comisión Tejana de Compensación para Trabajadores le ofrece asistencia gratuita, también puede que usted tenga derecho a ciertos beneficios médicos y monetarios. Para mayor información llame a la oficina local de la Comisión 1-800-252-7031.

TEXAS WORKERS' COMPENSATION WORK STATUS REPORT

| TEXAS WORK | THE COMPENSATION WORK STATE | JO KEPUKI | | |
|--|---|---|--|--|
| PART I: GENERAL INFORMATION | T I: GENERAL INFORMATION 5. Doctor's Name and Degree John M. Sanchez, MD | | | |
| 1. Injured Employee's Name | | purposes only) 08/29/2007 Employer's Name | | |
| Ronnie Morales | li li | CES Environmental | | |
| Date of Injury 3. Social Security Number | | Employer's Fax # or Email Address (if known) | | |
| 08/29/2007 (b) (4) | | 713)676-1676 | | |
| | | 1. Insurance Carrier | | |
| Patient states: "I was working a hose busted and I | | Texas Mutual Insurance Company | | |
| got chemical on my face and neck" | , | Carrier's Fax # or Email Address (if known) | | |
| | ` · · · · | (512)322-3889 | | |
| | | <u> </u> | | |
| PART II: WORK STATUS INFORMATIO | N (FULLY COMPLETE ONE INCLUDING ESTIMATED DATES A | ND DESCRIPTION IN 13(c) AS APPLICABLE) | | |
| 13. The injured employee's medical condition r | esulting from the workers' compensation injury: | , | | |
| X (a) will allow the employee to return to w | ork as of 08/29/2007 (date) without restrictions. | | | |
| | ork as of(date) with the restrictions id | entified in PART III. which are | | |
| expected to last through | | online in the transfer are | | |
| | nployee from returning to work as of(| date) and is expected to continue | | |
| | wing describes how this injury prevents the employee i | | | |
| (556)/ · · · · · · · · · · · · · · · · · · · | g 2000200 | , | | |
| | | | | |
| PART III: ACTIVITY RESTRICTIONS* (| REQUIRED IF BOX 13(b) IS CHECKED) | | | |
| 14. POSTURE RESTRICTIONS (if any) : | 17. MOTION RESTRICTIONS (if any): | 19. MISC. RESTRICTIONS (if any): | | |
| - | | Max hours per day of work: | | |
| Max Hours per day: 0 2 4 6 8 Other | | | | |
| Standing UUUU | _ Walking UUUU | Sit/Stretch breaks ofper | | |
| Sitting UUUU | Climbing stairs/ladders | Must wear splint/cast at work | | |
| Kneeling/Squatting | Grasping/Squeezing | Must use crutches at all times | | |
| Bending/Stooping | Wrist flexion/extension | No driving/operating heavy equipment | | |
| Pushing/Pulling | Reaching | Can only drive automatic transmission | | |
| Twisting | Overhead Reaching | No work/hours/day work: | | |
| Other: | Keyboarding | in extreme hot/cold environments | | |
| 15. RESTRICTIONS SPECIFIC TO (if applic | other: | at heights or on scaffolding | | |
| L Hand/Wrist R Hand/Wrist | 18. LIFT/CARRY RESTRICTIONS (if any): | Must keep | | |
| | eck May not lift/carry objects more thanlbs | Elevated Clean & Dry | | |
| | ack for more thanhours per day | No skin contact with: | | |
| L Foot/Ankle R Foot/Ankle | May not perform any lifting/carrying | | | |
| | Other: | Dressing changes necessary at work | | |
| Other: | | No running | | |
| 16. OTHER RESTRICTIONS (if any): | | 20. MEDICATION RESTRICTIONS(if any): | | |
| | | Must take prescription medication(s) | | |
| | | Advised to take over-the-counter meds | | |
| *These restrictions are based on the doctor's best under | erstanding of the employee's essential job functions. If a particular | Medication may make drowsy (possible | | |
| restriction does not apply, it should be disregarded. If r | nodified duty that meets these restrictions is not available, the patier | enfotu/driving issues) | | |
| should be considered to be off work. Note - these restr | ctions should be followed outside of work as well as at work. | safety/driving issues) | | |
| PART IV: TREATMENT/FOLLOW-UP A | DECINTMENT INFORMATION | | | |
| | | | | |
| _ | Expected Follow-up Services Include: | 7 | | |
| 692.41 Contact dermatitis and other eczema due | Evaluation by the treating doctor on 08/31/2007 | (date) at <u>11:45 am</u> am/pm | | |
| | | (date) at am/pm | | |
| | Physical medicineX per week forweeks starting | on (date) at am/pm | | |
| | | n (date) at am/pm | | |
| | None. This is the last scheduled visit for this problem. At | this time, no further medical care is anticipated | | |
| Date / Time of Visit EMPLOYEE'S SIGNATURE | DOCTOR'S SIGNATURE Visit Type: Role | of Doctor: Treating doctor | | |
| 08/29/2007 11:42 am | | Designated doctor Referral doctor | | |
| Discharge Time | | Carrier-selected RME | | |
| 08/29/2007 02:13 pm | ☐ Follow-up | DWC-selected RME Other doctor | | |

DWC FORM-73 (Rev. 10/05) Page 1



DIVISION OF WORKERS' COMPENSATION

Advanced Toxicology Network 4900 Outland Center Drive Ste 103 MEMPHIS, TN 38118 (888) 290-1150

UDS Result Form

Result Information

Center : Address :

CMC - Houston I-10 East

City:

10909 I-10 East Frwy Houston, TX 77029

Attn:

CMC/TX-HOUSTON I-10 EAST

Patient Name : Patient SSN :

(b) (4)

Profile :

DRUG SCREEN: 10 PANEL

Reason:

Post Accident

Rejection:

Date Collected: 08/29/2007

Date Received: 08/30/2007

Time: 2:10 PM Time: 12:10 AM

Date Reported: 08/30/2007 T

Time: 3:06 AM

Creatinine:

Ph:

Specific Grav:

Specimen ID:

Result:

Status:

Sub Acct :

Location:

Screened Summary

| Screened Summary | | | | | | |
|------------------|-------------|---------------|--|--|--|--|
| <u>Drug</u> | Cutoff/GCMS | Cutoff/Screen | | | | |
| Amphetamine | 500 | 1000 | | | | |
| Barbiturates | 200 | 300 | | | | |
| Benzodiazepines | 200 | 300 | | | | |
| Benzoyleogonine | 1 50 | 300 | | | | |
| Carboxy-THC | 15 | 50 | | | | |
| Methadone | 200 | 300 | | | | |
| Methaqualone | 200 | 300 | | | | |
| Opiates | 2000 | 2000 | | | | |
| Propoxyphene | 200 | 300 | | | | |
| Phencyclidine | 25 | 25 | | | | |

Comment Summary

NEGATIVE

Reported

NDOT

Contact Name: Prabhakar Thangudu

Mail Address: 4904 Griggs Rd

CES Environmental

HOUSTON, TX 77021

Comment



Result Summary

11.7

Janet Putnam, Lab Director

Date Printed: 08/30/2007 07:35:30

CUSTODY AND CONTROL FORM (DO NOT USE THIS FORM FOR D.O.T. COLLECTIONS)

ADVANCED TOXICOLOGY NETWORK,

314357964

3560 Air Center Cove, Memphis, TN 38118 (888)222-4894 STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE A. Employer Name, Address, I.D. No. B. MRO Name, Address, Phone and Fax No. 本自的自己可 JACO BYCH-1885 - BTUAN HINDRA AD With the second to the same of 4 E ANDH. E., DA 40036 Prome: (1871) 488-8:08 Page: (18.00**85-1097** 73.616 C. Dopor Information Note: Dopor must sign HIPAA authorization on back of copy 1 D. Results Review SSN TILL HOUSE OF THE BOY-OF I IN SIGN WAS A LO SIVERE E. Reason for Test First Konnu M.I. . ☐ Pre-employment Name ☐ Random ☐ Reasonable Suspicion/Cause Post Accident ☐ Post Injury ☐ Return to Duty ☐ Follow-up Merales Other (specify): ___ Name F. Test to be Performed: Alt COURSE OF PRESENCE OF PAMEL ID Donor TIONA DRUG SCREEN: 10 PANEL Phone PESSON - ANTENNA 5 DERIG BANKS (A. 15) (Daytime Jalozi Daug academ: a Pame: Donor TANGUNG ALTOHOR GAINE LOCK LOC Phone (Evening) (optional) 1916098 DRUG BURREN: B FASEL W/ Buhanci Donor Certification: COLORS HERE COREMN ID FAMEL (L. DUI I certify that I provided my urine specimen to the collector; that I have not adulterated it in any manner; that each specimen bottle used was sealed with a tamper-evident seal in my presence; and that the information provided on this Collection Site Information 263 77237 073-7043 CONCERNIEN MAD 10 Mil CENTERS Collection Site Phone No. Site ID# 10909 T-10 WAST BREEWAY BOTTON TO 11023 (712) 573 7947 Collection Site Fax No. STEP 2: COMPLETED BY COLLECTOR Read specimen temperature within 4 minutes. Is temperature between Specimen Collection: ☐ Observed: 90° and 100° F? N∏ YES NO, enter remarks Single □ Split (Enter Remarks Below) REMARKS: STEP 3: Collector affixes bottle seal(s) to bottle(s). Collector dates seal(s). Donor initials seal(s). STEP 4: CHAIN OF CUSTODY - INITIATED BY COLLECTOR AND COMPLETED BY LABORATORY cedify that the specimen given to me by the donor identified above was collected, labeled, sealed and released to the Delivery Service noted, in accordance with applicable requirements. SPECIMEN BOTTLE(S) RELEASED TO: Signature of Collector 抗血结缔殖医疗 Liters. 082901. PRINT Collector's Name (First MI Last) Date (MM/DD/YY) Name of Delivery Service Transferring Specimen to Laboratory RECEIVED AT LABORATORY SPECIMEN BOTTLE(S) RELEASED TO: Primary Specimen Bottle Seal Yes No Stonature of Accessioner 不多的复数存储的 强化分配化

Date (MM/DD/YY)

PRINT Accessioner's Name (First MI Last)

enter remarks below

Alcohol Testing Form (Non-DOT) (The instructions for completing this form are on the back of Copy 3) STEP 1: TO BE COMPLETED BY ALCOHOL TECHNICIAN A: Employee Name (Print) (First, M.L. Last) all DMONITOR B: SSN or Employee ID No. 08. 29**/07** TEST NO. C: Employer Name 980: **464-83-7271....** Street SCREENING TEST 3/21**0L** OTUA DID. City, ST ZIP **DER Name and** Telephone No. DER Name DER (Area Code & Phone Number) Fost-Accident 🗌 Return to Duty 🔝 Follow-up 🔲 Pre-employment D: Reason for Test: Random Reasonable Susp. STEP 2: TO BE COMPLETED BY EMPLOYEE I certify that I am about to submit to alcohol testing and that the identifying information provided on the form is true and correct Signature of Employee STEP 3: TO BE COMPLETED BY ALCOHOL TECHNICIAN (If the technician conducting the screening test is not the same technician who will be conducting the confirmation test, each technician must complete their own form.) I certify that I have conducted alcohol testing on the above named individual, that I am qualified to operate the testing device(s) identified, and that the results are as recorded. DEVICE: ☐ SALIVA X BREATH* 15-Minute Wait: ☐ Yes SCREENING TEST: (For BREATH DEVICE* write in the space below only if the testing device is not designed to print.) Device Serial # OR Lot # & Exp. Date Activation Time CONFIRMATION TEST: Results MUST be affixed to each copy of this form or printed directly onto the form. REMARKS: Month STEP 4: TO BE COMPLETED BY EMPLOYEE IF TEST RESULT IS POSITIVE I certify that I have submitted to the alcohol test, the results of which are accurately recorded on this form, I understand that I must not drive, perform safety-sensitive duties, or operate heavy equipment because the results are positive. Signature of Employee Month / Day

471-FS-C3 (Rev. 6/01) 6363

001182

CC

50



08/30/2007

C E S ENVIRONMENTAL SERVICES I

4904 GRIGGS RD HOUSTON, TX 77021-3208

FOR FAST AND EASY CLAIM REPORTING, FILE YOUR CLAIMS ON-LINE AT www.texasmutual.com

Texas Mutual Insurance Company has received notice of an injury that occurred on 08/29/2007 to MORALES, RONNIE L.

The carrier claim number assigned to this claim is 99H0000501942.

FOR POLICYHOLDERS WHO HAVE SELECTED THE NETWORK OPTION ONLY - If you have network coverage at the time of the injury, you are required to obtain a second Employee Acknowledgement of Workers' Compensation Network Form. Please submit a copy of the second acknowledgement form to Texas Mutual. If you wish to speak to a TMI representative please call 1-800-859-5995. You may also refer to www.texasmutual.com for more information.

To review specific claim information, you may use our online system available through our website, http://www.texasmutual.com. If you do not have a Texas Mutual on-line services ID, please call Texas Mutual at (800) 859-5995 to obtain an ID.

Please refer to the Texas Department of Insurance, Division of 'ers' Compensation at http://www.tdi.state.tx.us for additional rmation including employer and employee rights and responsibilities.

Texas Mutual has contracted with ScripNet to ensure your employees obtain the prescription drugs needed to treat their work related injury. ScripNet is available seven days a week at 1-888-880-8562 to obtain a list of network pharmacies in your area or log on to http://www.scripnet.com.



For your records, below is a copy of the information used to establish this claim. Any additional claim, payment or employee wage information can be can be faxed to us at (512) 224-3889.

Policy Number: TSF0001086044 Employee Name: RONNIE MORALES Social Security Number (b) (4) Date of Birth: (6) (4) Marital Status: Married Gender: M Dependents: Spoken Language: E Home Phone: (b) (4) Employee Address 1: Employee Address City/State/Zip: (b) County (b) (4) Email Address
Hire Date: (b) (4) Hire State: TX Partner/Officer/Owner?: N Occupation: HELPER Rate of Pay: (b) (4) Frequency of Payment: Hourly Work Week: Pay Check k was for

> Texas Mutual Insurance Company 6210 E Highway 290, Austin, Texas 78723-1098 512.322.3800 /800.859.5995 / fax 877.404.7999 / www.texasmutual.com

Check Period Start Date: / /0 Check Period End Date: Is Employer planning to continue Employee's salary ?: If Yes, Gross Amount of Continued Salary: 0000000 rney/Representation ?: N L 3 of Injury: 08/29/2007 Time of Injury: 10:15:00 Date Lost Time Began: 10:15:00 Date Reported to Employer: 08/29/2007 Employee Working Regular Job: Y Return to Work Date: / /0 Body Part: MOUTH Nature: UNKNOWN/NOT REPORTED Cause: MISC. CAUSES-ABSORB, INGEST OR INHALATION, NOC Description: VOCAL AREA. CAUSTIC HOSE BROKE LOOSE SPRAYING CO Injury Address: 4904 GRIGGS RD City/State/Zip: HOUSTON TX 77021-County: HARRIS Witness Name: ROLANDO SOTO Witness Phone: () Fatality?: N Physician Name: Physician Phone: Physician Email: Tax ID Number: 76-0592985 Customer Location ID: Business Name: C E S ENVIRONMENTAL SERVICES I Business Address 1: 4904 CRIGGS RD Business Address 2: City/State/Zip: HOUSTON TX 77021-3208 Employers Phone: (713) 676-1460 Supervisor's Name: BRIAN WEATHERS Supervisor's Phone: Supv. Email: Preparer's Name: PRABHAKAR THANGUDU Preparer's Phone: (713) 676-1460 Prep Email:

EPAHO043000051

Aug 14, 2007 Accidentate
6500 Brittmane Rd

U.S. Postal Service CERTIFIED MAIL RECEIPT 2459 (Domestic Mail Only; No Insurance Coverage Provided) サカロヨ PASADENA TX 77505 Postage \$0.41 0027 0002 \$2.65 06Postmark Return Receipt Fee (Endorsement Required: Here \$2,15 1000 Restricted Delivery Fee (Engarsement Required) \$0.00 Total Postage & Fees \$ \$5,21 J09/11/2007 7002 Sent To Hams County Public health + Envion. Services Street, Apt. No. or PO BOX NO. 107N MURGES City, State, 219-4 PADAGENA PS Form 3800, April 2002 77506

FOSTER PLACE STATION HOUSTON, Texas 770219998

4841490027-0097

09/11/2007 (800)275~8777 01:17:58 PM

Product Sale Unit Final
Description Qty Price Price

PASADENA TX 77506 \$0.41

Zone-1 First-Class

Letter 0.80 az.

Return Ropt (Green \$2.15

Card)

Certified \$2.65 Label #: 70021000000544232459

70021000000544232459

Issue PVI:

\$5,21

Total: \$5.21

Paid by:

Cash \$5.21

Order stamps at 1990 (1) or call 1-800-Stamps 4 (a) by USPS.com/ 1/200-pp to 2 shipping offer of mater of the lot emater 1 with USPs

B-11#:1000300222 // Clerk:06

All sales final on standards.

Refunds for guarantee Greene was Thank you for your business.

nttprin

TELL US ABOUT YOUR RECENT POSTAL EXPERIENCE

Customer Copy

| SENDER: COMPLETE THIS SECTION | COMPLETE THIS SECTION ON DELIVERY | | | |
|--|--|--|--|--|
| Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. Print your name and address on the reverse so that we can return the card to you. Attach this card to the back of the mailpiece, or on the front if space permits. | A. Signature X | | | |
| 1. Article Addressed to: Hams County Public Health and Environmental Service AHN James Walls | D. Is delivery address different from item 1? | | | |
| 107 N. Munger Pasadena, TX 1750le | 3. Service Type Certified Mail Express Mail Registered Return Receipt for Merchandise C.O.D. 4. Restricted Delivery? (Extra Fee) | | | |
| 2. Article Number (Transfer from service label) 7002 188 | | | | |
| PS Form 3811, February 2004 Domestic Ref | um Receipt 102595-02-M-1540 | | | |

United States Postal Service

First-Class Mail Postage & Fees Paid USPS Remit No. G-10

Sender: Please print your name, address, and ZIP+4 in this box

CES Environmental

490 4. Grigan Rd.

Howdon, TX 17021

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September 7, 2007

To: James Walls

Harris County Public Health & Environmental Services

107 N. Munger

Pasadena, Texas 77506

From: Karl A. Guidry

HSE Manager

CES Environmental Inc.

4904 Griggs Rd.

Houston, Texas 77021

Re: Violation Letter Dated August 28, 2007

CERTIFIED MAIL – RETURN RECEIPT REQUESTED

Dear Mr. Walls,

This response is submitted in reference to your letter dated August 28, 2007 regarding an August 14, 2007 violation of the Texas Water Code: Section 26.12 (a) and Harris County Storm Water Regulations Part E, Section 1.02

Summary:

A CES Environmental driver was on site at 6500 Brittmoore Rd to vacuum drums of gear oil. Total number of drums cleared was thirty (30) each containing ~ fifty (50) gallons of gear oil. Upon completion of clearing drums of their content, the CES driver noticed gear oil product leaking from the main vacuum truck door seal. CES Environmental and facility personnel estimated ~ seven hundred gallons of gear oil spilled onto the customers' property and entered into the facility drainage system.

Immediate Corrective Action

- 1. CES Vacuum truck 104 already onsite began clean-up operations.
- 2. CES Account Manager Gary Brauckman on site, notified CES Dispatch of spill.
- 3. 11:30 am CES Environmental Manager Karl Guidry arrived on site and began assessment of situation.
- 4. 11:30 am CES Vacuum Tanker 259 arrived on site.

- 5. 11:30 am CES Vacuum Trailer 204 arrived on site.
- 6. CES personnel verified level in vacuum truck estimated to be ~ 800 gallons.
- 7. CES personnel estimated ~ 700 gallons of gear oil spilled onto clients property.
- 8. 11:45 am CES Spill Response Crew began clean-up operations in spill area.
- CES and facility personnel assessed facility sumps and retention pond and found
 evidence of large volume of spill contents in sump near facility warehouse 2.
- 10. No evidence of spill contents in retention pond. (Cole Creek) Preventative measures taken include placement of 12' and 6' oil booms at retention pond inlet and two sumps.
- 11. Manhole on Brittmoore Road was pulled and no evidence of spill contents found.
- 12. <u>Karl Guidry notified David Buster of City of Houston Public Works and Engineering and Denise Hall of Harris County Pollution Control of the situation and need for assessment of impact on public water way.</u>
- 13. Facility personnel notified TCEQ and U.S. Coast Guard to apprise them of the situation.
- 14. 2:15 pm Ground level clean-up complete. Approved by facility personnel.
- 15. 2:30 pm CES staged equipment and began skimming process from facility sumps.
- 16. CES 20,000 gallon capacity frac tank arrived on site.
- 17. <u>Maverick Thigpen, Environmental Investigator for City of Houston arrived to assess</u> manholes on Brittmoore. Verified no spill product in manhole or public waterway.
- 18. Lee Nunn, Emergency Response Specialist of Harris County Public Health & Environmental Services arrived on site to assess situation. Verified no spill contents in manholes on Brittmoore and no spill content impact on nearest public waterway identified by Harris County as Cole Creek (facility retention pond).
- 19. Line jetting truck arrived on site and staged for line jetting facility drains.
- 20. 6:00 pm Facility drains were jetted using 2,000 psi and 82 gpm first time.
 Anthony Williams of U.S. Coast Guard arrived onsite to assess situation and informed
 CES and facility personnel no action will be taken by U.S. Coast Guard. Mr. Williams informed all persons involved in the cleanup the Coast Guard responded as part of the
 TCEQ protocol requiring Coast Guard notification when public waterways are at risk of being impacted by an environmental event. The Coast Guard determined the location of the spill was so far away from the Houston Ship Channel it required no action on their part.

Conclusion

Approximately 98% of spill volume was removed from facility sumps using a vacuum skimming process over a two day period. CES Environmental also jet cleaned drainage pipes and resumed skimming operations. Clean-up efforts were approved and results accepted by facility management personnel. Total spill volume estimated to remain in facility drainage system is 14 gallons, primarily material attached to concrete walls of drainage system. At no time did any gear oil from the spill ever reached Cole Creek, the nearest public waterway which could have been impacted.

If you have any questions regarding this response, please contact me at 713-676-1460 Office, 832-287-0862 Cell or kguidy@cesenvironmental.com.

Karl A Guidry

HSE manager

CES Environmental, Inc.

4904 Griggs Rd.

Houston, Texas 77021

Herminia Palacio, M.D., M.P.H. Executive Director 2223 West Loop South Houston, Texas 77027 Tele: (713) 49-6060 Fax. (713) 49-6080 B. Z. (Bud) Karachiwala, M.S., M.B.A. Director Environmental Public Health Division 107 N. Munger Pasadena. TX 7506 Tele: (713) 740-8703 Fax: (713) 477-8963

August 28, 2007

VIOLATION NOTICE

CES Environmental Services, Inc. 4904 Griggs Road Houston, TX 77021

Dear Sir or Madam:

The circumstances described below constitute violations of Chapter 26 of the Texas Water Code and Harris County Storm Water Regulations. You are requested to inform this office in writing within ten (10) days of the steps being taken to be in compliance with this law and to prevent recurrence. If the services of a consultant have been used in making your response, please provide us with their name and address.

NAME OF OFFENDER: CES Environmental Services, Inc.

PERSON(S) CONTACTED: Karl Guidry

NATURE OF VIOLATION:

On August 14, 2007 at 2:30 p.m., Lee Nunn of this office conducted an investigation at the LeTourneau Technologies Facility located at 6500 Brittmoore Rd. As a result of this investigation, it was determined that CES Environmental Services, Inc. is in violation of the following section of the Texas Water Code:

Section 26.121(a) Except as authorized by the commission, no person may:

| www.hcphes.org |
|----------------|

VIOLATION NOTICE CES Environmental Services, Inc. August 28, 2007 Page 2

(1) discharge sewage, municipal waste, recreational waste, agricultural waste, or industrial waste into or adjacent to any water in the state:...

A CES Environmental Services, Inc. vacuum truck discharged approximately 700 gallons of waste oil into the storm drain system at the LeTourneau Technologies Facility which empties into Cole Creek.

Consequently, you are in violation of the following regulation:

Harris County Storm Water Regulations Part E, Section 1.02

- (a) No person shall discharge or cause to be discharged into the Municipal Separate Storm Sewer System (MS4) anything that is not composed entirely of storm water except the following:
 - 1. A discharge authorized by, and in full compliance with, an NPDES or TPDES permit (other than an NPDES permit issued to a governmental entity for discharges from the MS4)...

25. ...

Under the Texas Water Code you are subject to civil penalties of \$50 to \$25,000 per day, criminal penalties of up to \$250,000 per day or more for each violation, and possible confinement up to 10 years or more. Under the Regulations of Harris County for Storm Water Quality Management, you may be subject to civil penalties up to \$1,000 per day. A case-by-case review is conducted when each Violation Notice is issued. The ultimate disposition of each case is dependent upon factors such as the nature, magnitude and duration of this violation, steps taken to mitigate the violation, previous violations, and the contents of any response received. In the event that further enforcement action is appropriate, this office may file charges in a court of proper jurisdiction, as provided by law. Should you have any questions concerning this Violation Notice, or wish to arrange a conference to discuss any compliance plan, please call Lee Nunn at 713-740-8728.

for B. Z. Karachiwala, Director

Environmental Public Health Division

LN/tr

www.hcphes.org

EPAHO043000061

Brent Sittigs Accin Spill 4-5-07

markin called about 11:30 and and reported that Prent had a problem horses on the his trailer and spilled about go god hydranist oil on the feeder 610 west Rend leve at Homestead. Milstead sesponded to the scene of spill. Cleared up the spill with classiball and downweed it in 3 drums, Tx DOT send truck used about 2 yards send to spread it on the area, of There was also some spill in the ditch but it was curtained and the mil was supped up from the ditch. By I pur the spill was cleaned and everybody left the scene. Milstead dropped off the drums at CES.



| | | | | _ | |
|--------------|-----|-----|-------------|---|--|
| Contract No |) - | 7 ~ | $\wedge 11$ | 7 | |
| Contract No. | ı — | 1 | ω_H | / | |

Milstead Environmental

| Contrac | | | | | |
|---------------------|---|---|---|----------------------------------|--|
| | | ENV | /IRONMENTAL SERV | ICES CONTRACT | |
| TI: 0 | 5-11 | <u></u> | Ancil | | |
| This Co | ontract ("Contract") is effective as of the 5+10 | day of | stomer'). | | , 20 by and between Milstead Environmental. ("Contractor" or "MILSTEAL |
| | | | | MENTAL to perform hazardo | ous materials emergency response services, oil spill response, engineering, consulting, an |
| | l on services; and | recodures by which it may | arnaditiously angus to navform ha | zardous materials americanous | response services, oil spill response, engineering, consulting, and remediation services for |
| Custome | er. The undereigned parties hereby agree as follows: | | expeditionary engage to perform ha | cardous materials emergency i | esponse services, on spin response, engineering, consuming, and remediation services re |
| 1. <u>C</u> | ontract term. This Contract shall apply for the applicable to Single project as specified in the attached Work Order. | erm indicated below: | • | | |
| 1 |] Through period ending on the | day of | | | 0 |
| | When no option is selected above, the Contract will remain in the cancellation or expiration of the term of this Contract shall | | | | either Party cancels it prior to that time by written notice to the other; provided, howeve tration or cancellation. |
| 2. <u>O</u> a. | | nd nature of the services re | | | ED ENVIRONMENTACS 24-hour emergency response telephone number (888-942-9628) (IRONMENTAL on-call supervisor will be contacted and will call the Customer back an |
| b. | | • | ssible, and no later than 24 hours th | ereafter, Customer shall delive | er the attached, executed Work Order to MILSTEAD ENVIRONMENTAL either in perso |
| c. d | specifically incorporates all of the terms and conditions Purchase Order. | of this contract by reference | ce and the form provides that the te | rrns of this Contract will be in | ains the same information as the MILSTEAD ENVIRONMENTAL Work Order, the form neorporated therein and will supersede any conflicting terms or conditions printed on the |
| 3. <u>P</u> | Price. Unless otherwise indicated on the Work Order, all wor | rk performed hereunder sha | Ill be priced on a time and materia | basis in accordance with the | MILSTEAD ENVIRONMENTAL Time and Material Rate Schedule ("Rate Schedule" |
| T | | e effective with respect to v | | | FEAD ENVIRONMENTAL may from time to time amended its Rate Schedules or Wor ENVIRONMENTAL prior to MILSTEAD ENVIRONMENTAL's notification to Custome |
| 4. <u>Ir</u> a. | | | | | under any Order, less prior payments received; provided, however, it shall not submit suc |
| b | invoices more frequently than daily. For Lump Sum Woo Final Invoice, After the work under an order is comple issue a final invoice setting forth the total amount due for | ted and all charges for the | associated subcontracts, vendor, an | | en received by MILSTEAD ENVIRONMENTAL, MILSTEAD ENVIRONMENTAL sha |
| c. | . Payment. Payment is due under each progress or final in | ivoice within 10 days after t | he date of the invoice unless otherw | | ENVIRONMENTAL. Interest shall accrue on payments not received within thirty (30) day AD ENVIRONMENTAL reserves the right to withhold delivery of reports and other project. |
| | | | | | rms specified above, regardless of whether Customer or another person or entity is legall uch costs from his or from some other person's or entity's insurance carrier. |
| | Fermination for Non-Payment. In the event Customer fails to nd/or any or all Work Orders for non-payment and seek recovered. | | | AD ENVIRONMENTAL may | stop work under any Work Orders issued and accepted and may terminate this Contract |
| 7. <u>i</u> | nformation and Authorization. For each Work Order issued | and accepted hereunder, Cuted, including any special ha | ustomer shall furnish to MILSTEAI izards or risks involved with such w | ork, premises, site or condition | tinent data and information concerning the work to be performed; the nature of Customer as. Such information shall be included on the Work Order. Customer shall procure any an analysis of basely a successful procure and an analysis of basely and the successful procure and the successful pro |
| | in applicable rederal, state, or local approvals, consents, perm Compliance with Environmental Laws. | nts, neenses and Orders req | uirea to enable MILSTEAD ENVI | RONMENTAL to perform the | work contemplated nereby. |
| a. | to any legal or equitable restraint or Order that prohibits | the treatment, storage and | or disposal of such waste by any tr | ansporter or disposal facility. | e property of Customer or other third party. Customer further warrants that it is not subject |
| . b | Resource Conservation and Recovery Act, as amended (| ("RCRA") and all other app | olicable federal, state, or local laws | statutes, or regulations gover | minants that are the subject of this Contract and for full compliance with provisions of the ning the treatment, transportation, storage, or disposal of waste or material. d in the Scope of Work; (ii) the operator of a waste management facility; (iii) the generato |
| C | storer, or disposer of hazardous or solid waste; (iv) to ha | ave arranged for the transpo | rtation or disposal of any wastes, p | ollutants, or contaminants by | virtue of the performance of this Contract or anything contained herein, as those terms at gulation governing the treatment, transportation, storage, or disposal of materials or waste |
| . d | analytical testing to assist Customer in the characteriza | tion of waste for the purpo | se of Customer's manifests; (ii) id | entify a number of potential to | AD ENVIRONMENTAL as requested by Customer may (i) collect samples and perfor ransporters and disposal facilities from which Customer may select in accomplishing the control of the control of the customer may be controlled to the customer may be |
| | solely by Customer. | t the technical provisions o | contracts of purchase Orgers and | prepare manifests implement | ing Customer's selection of a transporter and/or disposal facility for review and execution |
| r l | | be suitable for the size and | | | ss the work site under any Work Order issued and accepted hereunder. Customer warran L to perform the work. Customer agrees to bear the costs of all construction, modification |
| 10. <u>I</u> . a | | | | | es and agents, from and against any and all claims, demands, causes of action and liabilities |
| ь | demand, cause of action and/or liability is attributable to | o the breach of contract, ne | gligence, or other fault of the inder | nnifying party. | act and/or the conditions to which this Contract pertains, to the extent that any such claim astomer will be liable under any circumstances to the other for any special, consequential |
| 0 | incidental, indirect or punitive damages of any kind or c | haracter, including, but not | limited to, loss of use, loss of profi | , loss of revenue, and loss of p | product or production, whether arising under this Agreement or as a result of, relating to the a claim for such damages against the other or the other's related entities, their officer |
| | directors, shareholders, employees, servants, agents or i | nsurers whether such claim | is based or claimed to be based or | negligenee, unseaworthiness, | fault, breach of warranty, breach of agreement, statute, strict liability or otherwise. |
| | Notices. All Work Orders acceptances or rejections of Work O | Orders, notices, communica | tions or statements required to be g | Customer Name: A. F. | S Dlix omments |
| | W. Hawthorne | | | Street Address: | 4904 briggs Rd. |
| Spring, | TX 77386 | | | City, State Zip: | gus ton, 1x, 11 |
| • | one: 281.367.3535 | | | Telephone: |) 6 /6 / 760 |
| Facsimi | ile: 281.292.0666 | | | Contact: | In Waser |
| | MILSTEAD ENVIRONMENTAL | | | comact. | |
| | Tity, State Zip: <u>Spring, TX 77386</u> Felephone: <u>281.367.3535</u> | | | | |
| Local I | FAX: <u>281.292.0666</u> | | | | |
| | Entire Agreement, This Contract and the Exhibits hereto consists expressly stated in this Contract and Exhibits, and the pa | | | | gagements, promises, representations, or warranties have been made by either party exce all be in writing, signed by both parties hereto. |
| | Venue. The parties stipulate and agree that this Contract and proceeding for the enforcement hereof is proper in Harris Contract. | | accepted hercunder are entered int | o in Harris County, Texas, and | d all payments due hereunder are due in Harris County, Texas, and that venue to bring a |
| 14. <u>l</u> | Breach. Any controversy or claim arising out of or relating to | this Contract, to any Work | Order issued and accepted hereun | der, or the breach of either sha | ill be settled under the laws of the state of Texas. |
| | Attorney's Fees. The prevailing party in any legal proceeding reasons of suit from the non-prev | · - | visions of this Contract or any World | Order issued and accepted he | ereunder shall, in addition to such other relief as may be awarded, be entitled to recover |
| THIS | CONTRACT INCLUDES THE FOLLOWING DOCUME | ENTS: (check as applicable | ·) | | |
| [1 | Environmental Services Contract, three (3) pages. Work Order, two (2) pages. | Date Clarification | -: (0) | | |
| | MILSTEAD ENVIRONMENTAL Time and Materials Modification of Order, one (1) page. Credit Card Payment Guarantee. | Kate Sheet, dated 10-13-04 | , nine (9) pages. | | |
| [[| Credit Card Payment Guarantee. | <u> </u> | | ^ | |
| Agreed | d to and accepted this | bert — | , 2007. | KOA | CES Emvironental |
| MILS | TEAD ENVIRONMENTAL . | ÷ | • | CUSTOMER: | The Thirthowenes |



Milstead Environmental Service

29707 West Hawthorne Spring, Texas 77386 Office: 281-367-3535

Fax: 281-419-4492

Letter of Authorization for Disposal

| Milstead Job # | 1.7-0117 | |
|----------------|----------|--|
| | | |

This letter is being submitted to reflect and document that the Generator listed below has granted full and complete authorization, for *Milstead Environmental* (agent) to sign all waste documents on behalf of Generator.

This document herby authorizes *Milstead Environmental* to function in the capacity of (generator, as that term is defined in state and federal rules and regulations) with regard to legally proper waste classification, representation, shipment and disposal and to otherwise act as Generator's agent to characterize, ship, dispose and otherwise represent all waste streams in accordance with all local, state and federal rules and regulations. Such authorization includes but is not limited to execution of the following types of waste-related documents:

- Waste Characterization Data (WCD) Forms/Waste profiles
- Waste Manifests Uniform Hazardous Waste Manifests and Non-Hazardous Manifests
- Process Knowledge Forms or Letters
- Waste Profile Amendment Request Forms
- WCD/Profile Recertification Forms
- Land Ban Forms
- · One Time Waste Shipment Forms/Authorizations

Milstead Environmental (agent) is required to provide Generator with copies of all documents executed in accordance with this authorization. This authorization will expire on (Expiration date) ______ or when the generator provides written notice to revoke this authorization.

Generator's Printed Name

Wriver

Generator's Signature

Company Name

Date

Penny Foster Accident
19-13-2007

EPAHO043000065



Claim & Information Services P.O. Box 12029 Austin, TX 78711-2029 1-800-859-5995 (512) 224-3800

Fax (512) 224-3889

October 10, 2007

C E S ENVIRONMENTAL SERVI 4904 GRIGGS RD HOUSTON, TX 770213208

Re:

Claim #:

Employee:

Soc. Sec.:

Employer:

C E S ENVIRONMENTAL SERVI

PERCY FOSTER

Date of Injury: 09/13/2007

DWC#:

Dear C E S ENVIRONMENTAL SERVI,

Thank you for submitting the attached Wage Statement. We have reviewed the form and have found information that must be changed to meet the requirements of the Division of Workers' Compensation. Please make the following corrections:

INCLUDE WAGES AFTER THE DATE OF INJURY

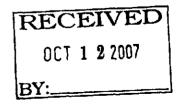
Please note that the salary history cannot include, nor go beyond, the date of injury.

Thank you for your prompt attention to this matter. If you have any questions, please call me at 1-800-859-5995.

Sincerely,

Angie Balderas **EXT 2121** WORKERS' COMPENSATION SPEC II

Enclosure: Wage Statement



| Send to workers' compensation carrier: | | CLAIM# | AIM# | |
|---|---|---|---|--|
| (Name and fax number of carrier) | | CARRIER'S CLAIM # | | |
| ☐ Initial ☐ Amended EMP | LOYER'S WA | AGE STATEN | IENT | |
| The Texas Workers' Compensation Act and Wor require an employer to provide an Employer's Wagdompensation insurance carrier (carrier) and the representative, if any. The purpose of the form is wage information to the carrier for calculating the er | Statement to its workers' daimant or the claimant's to provide the employee's | manner prescribed by the (1) The wage statement carrier, the claimant, and | ly file a complete waga statement in the form and Division. It shall be filed ("filed" means received) with the the claimant's representative (if any) within 30 days | |
| Wage (AWW) to establish benefits due to the emplo | yee or a beneficiary. | of the earliest of: | nhih day of dischility. | |
| The AWW is based on the wages the employee earned in the 13 weeks immediately preceding the date of injury (or the wage a similar employee earned if the employee did not work the full 13-week period). "Wages" include all forms of remuneration payable to an employee for personal services, | | (A) the employee's eighth day of disability; (B) the date the employer is notified that the employee is entitled income benefits; (C) the date of the employee's death as a result of a compensable injury. | | |
| including fringe benefits. To simplify filing, emplo monthly, biweekly, or weekly manner as discussed b | yers may file wages in a | | shall also be filed with the Division within sever st from the Division (Only When Requested). | |
| NOTE - An employer who fails without good cause to timely file a complete wage statement as required by the Texas Workers' Compensation Act, Texas Labor Code, Section 408.063(c) and Worker's Compensation Rule 120.4 may be assessed an administrative penalty not to exceed \$500.00 for an initial offense and not to exceed \$10,000.00 for a repeated administrative violation. | | (3) A subsequent wage statement shall be filed with the carrier, employee and the employee's representative (if any) within seven days if an information contained on the previous wage statement changes (such as the employer discontinues providing a nonpecuniary wage that was initially continued after the date of injury). | | |
| | | All applicable DW | C rules can be found at www.tdi.state.tx.us | |
| EMPLOYEE AND EMPLOYER INFOREMPLOYER INFOREMPLOYEE'S Name (Last, First, M.I.): | RMATION | Employer's Business Nan | ne: | |
| Employee's Mailing Address (Street or P.O. Box): | 1,000 | Employer's Mailing Addre | ss (Street or P.O. Box): | |
| City: Stale: | ZIP Code: | City: | State: ZIP Code: | |
| Social Security Number: | | Federal Tax I.D. Number: | | |
| Date of Hire: Date of Injur | у: | Name and Phone # of Pe | rson Providing Wage Information: | |
| As of today's date, the employee is not back | at work. OR | | | |
| ☐ The employee returned to work on ☐ without restriction. OR ☐ with restrictions and is earning wages of week/month (circle one). NOTE - Rule 120.3 requires the employer file the trijury (DWC FORM-6) to report changes in Worth | \$per Supplemental Report of | I HEREBY CERTIFY THAT this wage statement is complete, accurate, an complies with the Texas Workers' Compensation Act and applicable rules and the listed wages include all pecuniary and nonpecuniary wages paid to (earned in) the 13 weeks prior to the date of injury (as described on page 2 and 1 understand that making a misrepresentation about a worken compensation claim is a crime that can result in fines and/or imprisonment. | | |
| Earnings. | | Signature: | Date: | |
| EMPLOYMENT STATUS AT TIME OF | INJURY (Check A | dl That Apply) | | |
| ☐ Full-time: employee who regularly works at least 30 hours per week and whose achedule is comparable to other employees of the company and/or other employees in the same business or vicinity who are considered full-time. ☐ Sessonal: employee who as regular course of employee whose work is employee whose work is employee. | | r Course of Conduct: history for the 12-month my shows the person only hat period. utar Course of Conduct: history for the 12-month my shows part-time and full lod. | ☐ Minor: employee less than 18 years of age and not emancipated by marriage or judicial action who is also an apprentice, trainee or student. ☐ Student: employee enrolled in a course of study in high school, college or other institute of higher education or technical training. | |
| nature and that does not continue throughout the year. | | e who is learning a skilled at experience under the | ☐ Traines: employee undergoing systematic instruction and practice in some art, trade or | |

SAME OR SIMILAR EMPLOYEE?

The wage information on this form is for:

☐ The Injured Employee OR ☐ A Similar Employee (NOTE — If requested by the Division, the employer shall identify the similar employee whose wages were provided.)

If the employee was not employed for 13 continuous weeks before the date of injury, report the wages of an employee who has training, experience, skills & wages comparable to the injured employee AND who performs services/tasks comparable in nature and in number of hours. If no similar employee exists, report the fimited available wages earned by the injured employee prior to the injury.

NOTE TO INJURED EMPLOYEE – if you were injured on or after 7/1/02, and had employment with more than one employer on the date of injury, you can provide your insurance carrier with wage information from your other employment for the carrier to include in your AWW and this may affect your benefits. Contact your carrier for additional information or call the Division at (800) 252-7031. You can also read rule 122.5 at www.tdi.state.tx.us.

direction of a skilled crafts person or artisan.

DIVISION OF WORKERS' COMPENSATION

profession with a view towards proficiency in it.

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| WAGE INF | ORMA | TION | INSTRU | ICTION | s | Emplo | yee Nam | e : | | | | Social | Security # | ħ. | | Da | ate of Injur | y: |
|---|--|--|---|--|---|--|--|---|---|--|--|---|---|---|---|--|---|--|
| employer may 4.34821. If th employer may not report wa | / provide le emplo / adjust t lges ear veekly ea | wages yee is p he repo ned on arnings, | for the 3 paid on a rting perio or after t use all 13 | 3 months biweekly od backw the date 3 Period : | preceding basis, the ard slighti of injury. Columns i | g the da employ y (up to pelow. I | ite of inju er may i six days) f reportin | ury. Mor provide to to line u g 3 mont | nthly wag ne wages p the rep ths of ear | es may a for the 1 orting tim | also be on the distance of the | onverted preceding with the e ert the wa | to week! g the date mployer's ges to we | y wages e of injur s natural eekly ear | by dividi y. When pay cycl | ing the gr setting to e. Howe r | oss moni he period ver, the e | othly basis, the thly amount by s to report, the employer shall and Columns. If |
| PECUNIAR | | | FORMA | TION | | comm comm comm | r, weekly, rissions. rissions) n f the empl | biweekly, Earnings leed to be loyee's eq | monthly, are report prorated, ulpment or | etc. wage: ed in the Pecuniary r for paying | s; salary; t periods th wages do phelpers o | tips/gratuiti ey are ear n't include or to reimb | es; plecev med, NOI payments urse for to | vork comp when the made by avel exper | ensation; ey are pa an emplo nses. Cor | monetary id and sor | allowance me (such burse the d aminds an | are not limited to: as; bonuses; and as bonuses and encloyee for the nounts from paid t not used. |
| PERIOD # (\ Month #, or I | | | 1 | 2 | 3 | 4 | | 5 | 6 | 7 | 8 | 9 | 10 | | 11 | 12 | 13 | |
| FROM DATE | | 7 | | | | 1 | | | | | | | | | | | | |
| TO DATE: | | | | | | | | | | | | | | | | | | TOTALS |
| # HOURS W | ORKE | D: | | ·- <u>-</u> - | <u> </u> | | | | | | <u></u> | | | _ | | | | |
| GROSS WA EARNED: | GES | | | | | | | | | | | | | | | | | |
| NONPECU | NIARY | WAG | E INFO | RMATIC | | | | | | | | | | | | nese includ | | not limited to, the |
| Nonpecuniary Wage Type | Provid | iloyer ed Prior njury? | | ecify Vai | ue Or Am | | med in | Each Re | | eriod Fo | r Each Be | | | | | Will E | mployer nue To vide? | Date Benefit Suspended (If suspended |
| | YES | NO | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | YES | NO | 1 |
| Health Insurance | | | | | | | - | | | | | | | | | | | |
| Laundry/ Cleaning | | | | | | | | | | | | | | | | | | |

Social Security #:

Employee Name:



Clothing/ Uniforms

Lodging/ Housing/

Food/ Meals Vehicle/ Fuel Other

Date of Injury:



Karl Guidry

HSE Manager

Office: (713) 676-1460 Fax: (713) 676-1676

4904 Griggs Rd. Houston, TX 77021 Mobile: (832) 287-0862 Email: kguidry@cesenvironmental.com

To: Texas Mutual Ans. Co.

AHn. Evelyn J Corley

Fran: KARI Guidry

FAX: 512-224-3889

Evelyn, His info is submitted for Percy Foster. We were Supposes to have fasted it already, however we dropped if on our end. I apologize

> Fegards, Kuldhily



Claim & Information Services P.O. Box 12029

Austin, TX 78711-2029

1-800-859-5995 (512) 224-3800

Fax (512) 224-3889

September 26, 2007

C E S ENVIRONMENTAL SERVICES I

4904 GRIGGS RD HOUSTON, TX 770213208

Re:

Claim #: Employee:

Soc. Sec.:

Employer:

Date of Injury: 09/13/2007

attachment. The following time frames apply.

PERCY FOSTER

C E S ENVIRONMENTAL SERVICES I

451-33-4059

DWC#;

In accordance with the Division of Workers' Compensation Rules, we are requesting that you submit the information indicated below. The DWC3 and DWC6 forms are available for printing from our website, www.texasmutual.com, under services, or from the division's website, www.tdi.state.tx.us. For your convenience, a DWC3 is now available for you to complete and submit on-line. It is located on our website, www.texasmutual.com under the Employers - Loss Run & Claims Detail Section. If you need assistance with filing the DWC3 on-line please contact me. If you do not have access to the Internet, we will be happy to send you a blank form.

DWC3 EMPLOYER'S WAGE STATEMENT (Rule 128.2) - Please fax or email attachment or use the on-line version (www.texasmutual.com).

DWC3SD EMPLOYER'S WAGE STATEMENT FOR SCHOOL DISTRICTS (Rule 128.7)

DWC6 EMPLOYER'S SUPPLEMENTAL REPORT OF INJURY OR ILLNESS (Rule 120.3) - Please fax or email

Within 10 days after:

- The end of each pay period in which the employee's carnings have changed as a result of the injury, OR
- The employee returns to work, or the employee, after returning to work experiences an additional day(s) of disability as a result of the injury.

Within 3 days after:

- The employee begins to lose time from work as a result of the injury, OR
- The employee returns to work, or the employee, after returning to work experiences an additional days(s) of disability as a result of the injury

AND

EMPLOYEE ACKNOWLEDGEMENT OF WORKERS' COMPENSATION NETWORK FORM (This form(s) shall be completed, signed and submitted). Please fax or send attachment via cmail as soon as possible.

Failure to provide the required information is an administrative violation and may result in the assessment of a penalty from the Division of Workers' Compensation.

Thank you for your prompt attention to this matter. If you have any questions, please call me at 1-800-859-5995.

Sincerely,

Evelyn J. Corley WORKERS' COMPENSATION SPEC II

| Send to workers' compensation carrier: |
|--|
| (name and fax number of carrier) |



| TWCC# | |
|------------------|--|
| CARRIER'S CLAIM# | |

| MInitial | Amended |
|----------|---------|

EMPLOYER'S WAGE STATEMENT

The Texas Workers' Compensation Act and Commission rules require an employer to provide an Employer's Wage Statement to its workers' compensation insurance carrier (carrier) and the claimant or the claimant's representative, if any. The purpose of the form is to provide the employee's wage information to the carrier for calculating the employee's Average Weekly Wage (AWW) to establish benefits due to the employee or a beneficiary.

The AWW is based on the wages the employee earned in the 13 weeks immediately preceding the date of injury (or the wage a similar employee earned if the employee did not work the full 13-week period). "Wages" include all forms of remuneration payable to an employee for personal services, including fringe benefits. To simplify filing, employers may file wages in a monthly, biweekly, or weekly manner as discussed below.

NOTE - An employer who fails without good cause to timely file a complete wage statement as required by the Texas Workers' Compensation Act, Texas Labor Code, Section 408.063(c) and Commission Rule 120.4 may be assessed an administrative penalty not to exceed \$500.00 for an initial offense and not to exceed \$10,000.00 for a repeated administrative violation.

The employer shall timely file a complete wage statement in the form and manner prescribed by the Commission.

- (1) The wage statement shall be filed ("filed" means received) with the carrier, the claimant, and the claimant's representative (if any) within 30 days of the earliest of:
 - (A) the employee's eighth day of disability;
 - (B) the date the employer is notified that the employee is entitled to income benefits;
 - (C) the date of the employee's death as a result of a compensable injury.
- (2) The wage statement shall also be filed with the Commission within seven days of receiving a request from the Commission (Only When Requested).
- (3) A subsequent wage statement shall be filed with the carrier, employee, and the employee's representative (if any) within seven days if any information contained on the previous wage statement changes (such as if the employer discontinues providing a nonpecuniary wage that was initially continued after the date of injury).

| | | All applicable TWCC rules can be found at www.twcc.state.tx.us | | | | | | |
|---|---|--|--|--|--|--|--|--|
| EMPLOYEE AND EMPLOYER INFO | RMATION | | | | | | | |
| Employee's Name (Last First, M.L.): | | Employer's Business Nam | imental Tax | ك | | | | |
| Employee's Mailing Address (Street or P.O. Box): | | Employer's Mailing Addre | ss (Street or P.O. Box): | | | | | |
| C(b) (4) | | City: Houston | State: | ZIP Code: | | | | |
| S(b) (4) | | Name and Phone # of Per | 760592985 |) | | | | |
| Date of Hi (4) Date of Inju | 9-13-07 | Name and Phone # of Per | rson Providing Wage Into | ormation: GC | | | | |
| As of today's date, the employee is not back. The employee returned to work on 4-13-without restriction. OR with restrictions and is earning wages of week/month (circle one). NOTE - Rule 120.3 requires the employer file the Injury (TWCC-6) to report changes in Work Status and | and is working: \$ 480 per Supplemental Report of | I HEREBY CERTIFY THAT this wage statement is complete, accurate, and complies with the Texas Workers' Compensation Act and applicable rules, and the listed wages include all pecuniary and nonpecuniary wages paid for (earned in) the 13 weeks prior to the date of injury (as described on page 2) and I understand that making a misrepresentation about a workers' compensation claim is a crime that can result in fines and/or imprisonment. Signature: Date: 9-14-07 | | | | | | |
| EMPLOYMENT STATUS AT TIME OF | F INJURY (Check A | (II That Apply) | | | | | | |
| Full-time: employee who regularly works at least 30 hours per week and whose schedule is comparable to other employees of the company and/or other employees in the same business or vicinity who are considered full-time. Seasonal: employee who as regular course of conduct engages in seasonal or cyclical employment that may or may not be agricultural in nature and that does not continue throughout the year. | employee whose work period preceding the inju worked part-time during t Part-time: Not Reg employee whose work period preceding the inju time work during that per Apprentice: employed | ular Course of Conduct: history for the 12-month ry shows part-time and full iod. ee who is learning a skilled all experience under the | and not emancipated action who is also a student. Student: employed study in high school, of higher education or teat a student instruction and practice. | less than 18 years of age if by marriage or judicial an apprentice, trainee or see enrolled in a course of college or other institute of chnical training. The endergoing systematic can be some art, trade or towards proficiency in it. | | | | |
| SAME OR SIMILAR EMPLOYEE? | | If the employee was not employed for 13 continuous weeks before the date | | | | | | |
| The wage information on this form is for: The injured Employee OR A Similar requested by the Commission, the employer semployee whose wages were provided.) | Employee (NOTE – If shall identify the similar | of injury, report the wages of an employee who has training, experience, skills & wages comparable to the injured employee AND who performs services/tasks comparable in nature and in number of hours. If no similar employee exists, report the limited available wages earned by the injured employee prior to the injury. | | | | | | |
| NOTE TO INJURED EMPLOYEE – If you were injuprovide your insurance carrier with wage information Contact your carrier for additional information or call | n from your other employn | nent for the carrier to include | de in your AWW and this | may affect your benefits. | | | | |



TEXAS WORKERS' COMPENSATION COMMISSION



| TWCC# | |
|----------|--|
| Carrier# | |

SUPPLEMENTAL REPORT OF INJURY

| Part I EMPLOYER INFORMATION | | | | | | | | | | | |
|---|---|--|--|--|--|--|--|--|--|--|--|
| 1. Employer business name CES ENVIRORM | rendal, Ivc | 2. Employer phone # 713 ~ 6.76 ~ /460 | | | | | | | | | |
| 3. Employer mailing address 4904 Graggs 7 | 20. Houston, TX 7 | 7071 | | | | | | | | | |
| 4. Insurance carrier name TEXAS Mutu | al Ins. Co. | | | | | | | | | | |
| 5. Does the employer have return to work (RTW) opport | ortunities available based on the injured w | orker's current capabilities? yes 🖬 no 🔲 | | | | | | | | | |
| If so, identify contact person and phone | * KARLA Guidry | 113-676-146D | | | | | | | | | |
| 6. Has the insurance carrier provided RTW coordination services within the past 12 months? yes DATE no | | | | | | | | | | | |
| 7. Has the employer requested RTW training from TWCC or the insurance carrier? | | | | | | | | | | | |
| 8. Has the insurance carrier provided accident prevention services in the past 12 months? yes 🗹 DATE no 🔲 | | | | | | | | | | | |
| 9. Has the emptoyer requested accident prevention se | ervices from the insurance carrier? | yes 🗹 no 🗔 | | | | | | | | | |
| | Part II REASON FOR FILING THIS REPORT (deadlines vary, see instructions) | | | | | | | | | | |
| 10. a. The injured worker returned to work in ei | · · | • | | | | | | | | | |
| b. The injured worker is earning more or le | ss than the pre-injury wage because of th | e injury: File within 10 days. | | | | | | | | | |
| c. The injured worker returned, then later h | nad additional lost time or reduced wages | as a result of the injury: File within 3 days. | | | | | | | | | |
| d. The injured worker resigned or was term | inated from employment: File within 10 d | ays. | | | | | | | | | |
| Part III INJURED WORKER INFORMATION | | Long | | | | | | | | | |
| 11. Injured worker name PERCY Foster | 12. SSI(b) | (4) 9-13 07 | | | | | | | | | |
| ¹⁴ (b) (4) | | - | | | | | | | | | |
| 15. First day of lost time or reduced wages for this injury (mm/dd/yyyy) | 16. First day or reduced | of additional lost time wages (mm/dd/yyyy) | | | | | | | | | |
| 17. Has the injured worker experienced 8 days (cummi | | a result of the injury ? yes no | | | | | | | | | |
| If yes, the date of the 8th day (mm/dd/yyyy) | <u> </u> | | | | | | | | | | |
| 18. Date of most recent RTW <u> </u> | 19. Has the injured worker resigned, be | , | | | | | | | | | |
| Full duty, full pay | date of resignation date | e of termination $\frac{\mathcal{N}/\mathcal{A}}{\mathcal{A}}$ date of death $\frac{\mathcal{N}/\mathcal{A}}{\mathcal{A}}$ | | | | | | | | | |
| Limited duty, full pay | 19a. Reason for resignation/termination | | | | | | | | | | |
| Limited duty, reduced pay | N/A | | | | | | | | | | |
| | 19b. Was the injured worker on limited of | duty when terminated? yes no | | | | | | | | | |
| 20. Hours the injured worker was working during the p | pay period of 21. Weekly | hourly earnings for the pay period of $9 - 10 - 67$ | | | | | | | | | |
| Menclay to Friday: 40 hour | to Ch-14 | -C-7_: \$ weekly or \$ (6) (4) hourly | | | | | | | | | |
| Indicated hours are: Increase from pre-injury | Indicated | wages are: Increase from pre-injury wage | | | | | | | | | |
| Same as pre-injury | | Same as pre-injury wage | | | | | | | | | |
| Decrease from pre-injury | | Decrease from pre-injury wage | | | | | | | | | |
| This form to be filed with: The employ | er's insurance carrier and the injure | d worker in the timeframe as noted in Part II. | | | | | | | | | |
| 22. To the best of my knowledge, the information provi Submitted by: Employer | ded in this report is accurate and may be Injured Worker (if no longer working for | · | | | | | | | | | |
| | Nager | 9-14-07 | | | | | | | | | |
| Signature and Title of person completing this form | | Date | | | | | | | | | |

TWCC-6 (Rev 2/05) Page 1



TEXAS WORKERS' COMPENSATION COMMISSION

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| WAGE INFO | ORMA | TION I | NSTRU | JCTION | s | Employ | ee Nam | Pero | u Ç | stere | | Social | Security # | : +51-2 | 3-40 | C C, | ate of Injury | (: ら 7 |
|---|--------|----------------------------|---|--|---|---|--|---|---|---|---|---|--|---|---|---------------------------------------|-----------------------------|---|
| The employer shall report all wages earned in the 13 weeks immediately preceding the date of injury. If the employee is paid on a monthly or semi-monthly basis, the employer may provide wages for the 3 months preceding the date of injury. Monthly wages may also be converted to weekly wages by dividing the gross monthly amount by 4.34821. If the employee is paid on a biweekly basis, the employer may provide the wages for the 14 weeks preceding the date of injury. When setting the periods to report, the employer may adjust the reporting period backward slightly (up to six days) to line up the reporting timeframes with the employer's natural pay cycle. However, the employer shall not report wages earned on or after the date of injury. If reporting weekly earnings, use all 13 Period Columns below. If reporting 3 months of earnings, either convert the wages to weekly earnings or use the first 3 Period Columns. If reporting 14 weeks of biweekly earnings, use the first 7 Period Columns. In all cases, indicate the dates that each period covers. | | | | | | | | | | | | | | | | | | |
| PECUNIAR | | | hourly, commis commis use of t | weekl y , sions. sions) n the empl | biweekly, Earnings eed to be oyee's eq | monthly, are repor prorated, uipment o | etc. wages ted in the Pecuniary or for paying | s; salary; t periods th wages do g helpers c | ips/gratuiti ey are ea n't include or to reimb | es; piecev rned, NOT payments urse for tra | vork comp when th made by avel exper | ensation ey are pa an emplo nses. Co | ; monetary aid and so byer to reim insider as e | allowance: me (such a burse the e | re not limited to: s; bonuses; and es bonuses and employee for the nounts from paid not used. | | | |
| PERIOD # (V Month #, or E | | | 1 | 2 | 3 | 4 | | 5 | 6 | 7 | 8 | 9 | 10 |) | 11 | 12 | 13 | |
| FROM DATE | | 9 | 3/16 | 9/9 | 9/2 | 8/2 | 8 | 198 | lia | | | | | | | | | |
| TO DATE: | | | | 9/15 | | 911 | | 258 | | | | | | | | | | TOTALS |
| # HOURS W | ORKEE | \. | | 45:17 | | 59.2 | | | | | | | | | | | | בר.747 |
| GROSS WAG EARNED: | GES | (b) | (4) | | | | | | | | | | | | | | | (b) (4) |
| NONPECUN | liary | WAGE | INFO | RMATIC | | | | | | | | | | | | | le, but are i | not limited to, the enefits. |
| Nonpecuniary Wage Type | Provid | loyer ed Prior jury? | Sp | ecify Valu | ie Or Am | ount Ear | | | | eriod For as used | | enefit Pro | vided P | rior To Ir | njury | Cont | mployer inue To vide? | Date Benefit Suspended (if suspended) |
| | YES | NO | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | YES | NO | |
| Health Insurance | / | | | | | | | | | | | | | | | \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ | • | N/A |
| Laundry/ Cleaning | | | | | | | | | | | | | | | | | | |
| Clothing/ Uniforms | | | | | | | | | | | | | | | | | | |
| Lodging/ Housing/ | | | | | | | | | | | | | | | | | | |
| Food/ Meals | | | | | | | | | | † | | | | | | | | |



Vehicle/ Fuel

Other

Send the specified copies to your

Workers' Compensation Insurance Carrier
and the injured employee.

*Employers - Do not send this form to the

Texas Workers' Compensation Commission,
unless the Commission specifically requests
a direct filing.

TWCC CLAIM #

TWCC CLAIM #

CARRIER'S CLAIM #

| | | EMPLO | /ER'S FIRST R | EPORT (| OF INJURY O | R ILLNE: | SS | | | |
|-----------------------|--------------------------------|----------------|------------------|---------------|------------------|--------------|---------------------------|------------------|----------------|----------|
| 1 Name (Last, Firs | it, M.I.) | 2. Sex | - | \neg | 15. Date of In | ury | 16. Time of Injur | y 17. Date Los | t Time | 1 . |
| Foster | Percy | | ☐ F ☑ M | | 9/13/0 | 7 | am 🗌 | MOA | IF | |
| 3 Social Security N | 4. Home Phor | e Lo Date | of Birth | | 18. Nature of | Injury* | 19. Part of Body | Injured or Expo | sed* | 1 |
| (b) (4) | | (b) (4) | | | Cut | | Finger | | | |
| 6. Does the Empley | ree Sp eak English? | f No | | | 20. How and | ∕Vhy Injury | /Illness Occurre | d* | | 1 |
| | ₩Yes □ No | | | } | Acciden | fal cu | twing. | a bon lo | Here | |
| 7. Race | 8. Ethnicity | | | | | | ry or Exposu r e (| | | 1 |
| 173.4.4 | | Λ | • | | | | incident occurre | | | 1 |
| BLACK | AFRICA | u Hme | MCHN | | | E Bldg | 17825 1 | | KO | 1 |
| (b) (4) | Ctroat or D.O. Bay | | | | City How | | State / X | Zip | | |
| City (b) (4) | _ | | | | 24. Cause of | Injury(fall, | tool, machine, e | tc.)* | |] |
| | | | | | 1-12.1 | | | | | |
| 10. Marital Status: | 1. 100.11 | 140.0 | | | 1001 | | | | | 4 |
| 11. Number of Depe | endent Children | 12. Spo | use's Name | | 25. List Witne | sses: IR | IVIN WOO | bank' | | |
| 13. Doctor's Name: | | | | | 26. Return to | work | 27. Did employe | e 28. Super- | 28. Date | 1 |
| 14. Doctor's Mailing | Address (Street or P.6 |).Box) | | | Date/or ex | epected | die? | visor's name | Reported | İ |
| | Medical Cont | 6 E S | | | | | , | Eleve | | |
| 10909 I | | 7:- | | _ | م م | | NC | , , | 9-13-07 | 1 |
| City Houston | State, TX | Zip 7 - | 7029 | | 9-13 | 01 | | phriciar | 75 67 | <u> </u> |
| 30. Date of Hire | 31. Was emple | | | 32. Ler | ngth of Service | in | 33. Length of S | ervice in Occup | ation | 7 |
| (b) (4) | Texas? | ✓Ye | s 🔲 No | C. | rent Position | (mm/yy) | (mm/ yy) | | | |
| | | | | (D) (2 | +) | | | MONTH | | ╛ |
| | n Classification Code | | | | cupation of Inju | | | | | 4 |
| 36. Rate of Pay at th | · | _ | 38. Last Payche | _ | 39. Is employ | ee an Owr | ner, Partner, or | Corporate Office | er? | |
| (b) (4) Weel | Hours (Hours) | Days | (Hours) | Days | 1 | | Yes | ∡ No | | |
| d Title | of Person Completing F | orm | | 41. Nai | ne of Business | 1-0 | | 1 1 | | ┪ |
| KARLL A. G | fundry HS | E MAN | AGER | | | (ES | <i>ENVIRO</i> | newal. | LNC | |
| | g Address and Telepho | ne Number | 2.2 / 21 //// | 43. Bus | siness Location | (If differer | nt from mailing a | iddress) | | 7 |
| 4904 GR | 11 | | 713-6767446 | | | 0 | | 7: - | | |
| City Hauston | State TX | | 7021 | City | · | State | | Zip | | |
| 44. Federal Tax Ider | ntification Number | | ary Standard Ind | | ssification | | fic SIC Code* | | emptroller Tax | x c |
| 7605929 | ensation Insurance Con | | Code* (4 digit) | | icy Number | (4 digit) | | payer No. | 760593 | 12 |
| TEXAS N | | .6 | | 13. , 01 | T; | SENO | 010860 | 44 | | |
| | accident prevention se | vices in past | 12 months? | ,1 | | | | | | 7 |
| Yes | Ner If yes, did yo | u receive the | m? Yes | ☐ No | | | | | | _ |
| 51. Signature and T | tle (READ INSTRUCTI | ONS ON INS | TRUCTION SHE | ET BEFO | RE SIGNING) | | C | | | 7 |
| × Fin | 1/1/1-/6 | 1 | | - | | Date | 9-14-0 | | | - |
| | | | | | | | | | | |

You may be entitled to know what information UT Arlington (UTA) collects concerning you. You may review and have UTA correct this information according to procedures set forth in UT System BPM #32. The law is found in sections 552.021, 552.-23 and 559.004 of the Texas Government Code.

Continued on next page

Employee - You are required to report your injury to your employer within 30 days if your employer has workers' compensation insurance. You have the right to free assistance from the Texas Workers' Compensation Commission and may be childled to certain medical and income bonofits. For further information call your local Commission field office or 1(800)-252-7031.



Trabajador - Es necesario que usted reporte su lesión a su empleador dentro de 30 dias a partir del día en que se lesionó, si su empleador tiene seguro de compensación para trabajadores. la Comisión Tejana de Compensación para Trabajadores le ofrece asistencia gratuita, también puedo que usted tenga derecho a ciertos bendicios médicos y monetarios. Para mayor información llame a la oficina local de la Comisión 1-800-252-7031.

TEXAS WORKERS' COMPENSATION WORK STATUS REPORT

| PART I: GENERAL INFORMATION | Doctor's Name and Degree Dan P. Browder, MD | (for transmission Date Being Sent purposes only) 09/24/2007 | | | | |
|---|--|---|----------|--|--|--|
| 1. Injured Employee's Name | 6. Clinic/Facility Name | 9. Employer's Name | | | | |
| Percy Foster | CMC - Houston I-10 East | CES Environmental | | | | |
| Date of Injury 3 Social Security Number | 7. Clinic/Facility/Doctor Phone & Fax | 10. Employer's Fax # or Email Address (if known) | | | | |
| 09/13/2007 (A) | (713)973-7943 (713)973-7947 | (713)676-1676 | | | | |
| Employee's Description of Injury/Accident | Clinic/Facility/Doctor Address (street address) | 11. Insurance Carrier | | | | |
| Patient states :"While at work I cut my left hand with | 10909 I-10 East Frwy | Texas Mutual Insurance Company | | | | |
| a knife while cutting tape." | City State Zip | 12. Carrier's Fax # or Email Address (if known) | | | | |
| | Houston TX 77029 | (512)322-3889 | | | | |
| PART II: WORK STATUS INFORMATIO | (FULLY COMPLETE ONE INCLUDING ESTIMATED DATES A | ND DESCRIPTION IN 13(c) AS APPLICABLE) | | | | |
| | esulting from the workers' compensation injury: | TO BESSEL TISH IN 10(5) AS ALL PEISABELY | | | | |
|) | ork as of _09/24/2007 (date) without restrictions. | | | | | |
| | | dentified in PART III, which are | | | | |
| expected to last through | *** | · | | | | |
| l en | | (date) and is expected to continue | | | | |
| | wing describes how this injury prevents the employee | from returning to work: | | | | |
| | | | | | | |
| PART III: ACTIVITY RESTRICTIONS* (| REQUIRED IF BOX 13(b) IS CHECKED) | | | | | |
| | | | | | | |
| 14. POSTURE RESTRICTIONS (if any): | 17. MOTION RESTRICTIONS (if any): | 19. MISC. RESTRICTIONS (if any): | | | | |
| Max Hours per day: 0 2 4 6 8 Other | Max Hours per day: 0 2 4 6 8 Other | Max hours per day of work: | _ | | | |
| Standing | Walking \ | Sit/Stretch breaks ofper | | | | |
| | | | - | | | |
| Sitting | _ Climbing stairs/ladders | Must wear splint/cast at work | | | | |
| Kneeling/Squatting | _ Grasping/Squeezing | Must use crutches at all times | | | | |
| Bending/Stooping | Wrist flexion/extension | No driving/operating heavy equipm | ent | | | |
| Pushing/Pulling | Bonching DDDD | | | | | |
| | _ Reaching | Can only drive automatic transmission | | | | |
| Twisting | Overhead Reaching | No work/hours/day work: | | | | |
| Other: | Keyboarding | in extreme hot/cold environmer | nts | | | |
| 45 050500000000000000000000000000000000 | oblet. Other: | | | | | |
| 15. RESTRICTIONS SPECIFIC TO (if applica | inie). | at heights or on scaffolding | | | | |
| L Hand/Wrist R Hand/Wrist | 18. LIFT/CARRY RESTRICTIONS (if any): | Must keep | | | | |
| LArm RArm N | eck May not lift/carry objects more thanlbs | Elevated Clean & Dry | | | | |
| □ L Leg □ R Leg □ B | ack for more thanhours per day | No skin contact with: | | | | |
| L Foot/Ankle R Foot/Ankle | May not perform any lifting/carrying | | | | | |
| | | Dressing changes necessary at wo | rĸ | | | |
| Other: | Other: | No running | | | | |
| 16. OTHER RESTRICTIONS (if any): | | 20. MEDICATION RESTRICTIONS(if a | | | | |
| | | | | | | |
| | | Must take prescription medication(s | <i>'</i> | | | |
| | | Advised to take over-the-counter me | eds | | | |
| | rstanding of the employee's essential job functions. If a particular | Medication may make drowsy (poss | sible | | | |
| | odified duty that meets these restrictions is not available, the patie | nt safety/driving issues) | | | | |
| should be considered to be on work. Note - these restri | ctions should be followed outside of work as well as at work. | | | | | |
| PART IV: TREATMENT/FOLLOW-UP AT | PPOINTMENT INFORMATION | | | | | |
| | Expected Follow-up Services Include: | | | | | |
| N00 0 11 11 11 11 11 11 11 11 11 11 11 11 | Evaluation by the treating doctor on | (date) at am | /pm | | | |
| 882.0 Hand Lac W/O Complication | Referral to/Consult withon | | /pm | | | |
| | Physical modicineX per week forweeks starting | on (date) at am. | | | | |
| | | | /pm | | | |
| | None. This is the last scheduled visit for this problem. A | | | | | |
| Date / Time of Visit EMPLOYEE'S SIGNATURE | I I | e of Doctor: Treating doctor | | | | |
| 09/24/2007 04:51 pm | ☐ Initial ☐ | Designated doctor Referral doctor | | | | |
| Discharge Time | | Carrier-selected RME | ır { | | | |
| 09/24/2007 05:17 pm | K Follow-up | DWC-selected RME | | | | |
| | | | | | | |

DWC FORM-73 (Rev. 10/05) Page 1



DIVISION OF WORKERS' COMPENSATION

Perof

Claim Number:

Concentra Medical Centers

10909 I-10 East Frwy Houston, TX 77029 Phone: (713) 973-7943 Fax: (713) 973-7947 **Service Date:** 09/24/2007 **Case Date:** 09/13/2007

Ext.:

Physician Activity Status Report

Patient: Foster, Percy
SSN: (b) (4)
Address: (b) (4)
Home:
Work: (713) 672-1700 Ext.:

Employer Location: CES Environmental

4904 Griggs Rd

Contact: Prabhakar Thangudu Role: DER/Primary

Role: DER/Primary

HOUSTON, TX 77021

Phone: (713) 676-1460 Fax: (713) 676-1676

This Visit: Time In: 04:00 pm Time Out: 05:17 pm

Treating Provider: John M. Sanchez, MD

Hand Lac W/O Complication

Address:

Auth. by:

Recordable: No

Visit Type: Recheck

Medications:

☐ Dispensed Prescription Medication to Patient☐ Dispensed Over-The-Counter Prescription

☐ Written Prescription given to Patient

Patient Status:

Diagnosis: 882.0

Regular Activity - Released from care

Return to regular duty on 09/24/2007

Remarks:

The prescribed activity recommendations are suggested guidelines to assist in the patient's treatment and rehabilitation. Your employee has been informed that the activity prescription is expected to be followed at work and away from work.

Anticipated Date of Maximum Medical Improvement:

Actual Date of Maximum Medical Improvement: 09/24/2007

Next Visit(s):

Employer Notice:

Patient Notice: It is essential to your recovery that you keep your scheduled appointments, but should you need to reschedule or cancel your appointment, please contact the clinic. Thank you for your cooperation.

To: Prabhakar Thangudu 7136761676

Employee - You are required to report your injury to your employer within 30 days if your employer has workers' compensation insurance. You have the right to free assistance from the Texas Workers' Compensation Commission and may be entitled o certain medical and income benefits. For further information call your local Commission field office or 1(800), 252-7031.



Trabajador - Es necesario que usted reporte su lesión a su empleador dentro de 30 dias a partir del día en que se lesionó, si su empleador tene seguro de comoensación para trabajacores. la Comisión Tejana de Compensación para Trabajadores le ofrece asistencia gratulta, también puede que usted tenga derecho a cienos beneficios médicos y monetarios. Para mayor información tilame a la oficina local de la Comisión 1-800-252-7031.

| Т | EXAS WORKE | ERS' COMPENSATION WORK STAT | US REPORT | |
|--|--|--|---|------------------------------------|
| PART I: GENERAL | | 5. Doctor's Name and Degree Dan P. Browder, MD | (for transmission purposes only) | Date Being Sent |
| Injured Employee's Name | ļi | 5 Clinic/Facility Name | 9. Employer's Name | - |
| Percy Foster | | CMC - Houston I-10 East | CES Environmental | |
| | ecurity Number | Clinic/Facility/Doctor Phone & Fax | 10. Employer's Fax # or Email A | ddress (if xnown) |
| 09/13/2007 (b) (4) | | (713)973-7943 (713)973-7947 | (713)676-1676 | |
| Employee's Description of Injury Patient states: "While at work | 1 | 3 Clinic/Facility/Doctor Address (street address) 10909 I-10 East Frwy | 11. Insurance Carrier | |
| a knife while cutting tape." | · · · · · · · · · · · · · · · · · · · | Dity State Zip | Texas Mutual Insurance Co 12. Carrier's Fax # or Email Add | |
| | | Houston TX 77029 | (512)322-3889 | |
| 13. The injured employee (a) will allow the emp (b) will allow the emp expected to last the injury of the control of the co | e's medical condition re- ployee to return to wa ployee to return to wa through <u>09/28/2007</u> ad still prevents the em (date). The follow | | dentified in PART III, w | hich are |
| 14. POSTURE RESTRIC | CTIONS (if any): | 17. MOTION RESTRICTIONS (if any): | 19. MISC. RESTRIC | CTIONS (if any): |
| | , | | I — | day of work: |
| |) 2 4 6 8 Other | Max Hours per day: 0 2 4 6 8 Other | Max Hours per | day of work. |
| Standing | JUUUU | Walking UUUU | Sit/Stretch brea | sks of per |
| Sitting | 0000 | Climbing stairs/ladders 🔲 🔲 🔲 📗 | Must wear splin | t/cast at work |
| Kneeling/Squatting | | Grasping/Squeezing | Must use crutch | |
| · | | | 1 🖹 | |
| Bending/Stooping | <u> </u> | Wrist flexion/extension | ☐ No driving/oper | ating heavy equipment |
| Pushing/Pulling | J∐∐∐∐ <u></u> | Reaching | Can only drive | automatic transmission |
| Twisting | | Overhead Reaching | □ No work/□ | hours/day work: |
| | | · | | • |
| Other: | <u> </u> | Keyboarding | ☐ In extreme | hot/cold environments |
| 15. RESTRICTIONS SPE | ECIFIC TO (if applical | ble): Other: | at heights o | or on scaffolding |
| ☐ L Hand/Wrist ☐ | R Hand/Wrist | 18. LIFT/CARRY RESTRICTIONS (if any); | X Must keep wour | nd |
| | R Arm Ne | | - - - - - | X Clean & Dry |
| ∐ L Arm | | | | - ' ! |
| ∐ L Leg ∐ | R Leg Ba | ck for more thanhours per day | ☐ No skin contact | . with: |
| L Foot/Ankle | R Foot/Ankle | ☐ May not perform any lifting/carrying | Dressing chang | es necessary at work |
| Other: | | Other: | No running | |
| 16. OTHER RESTRICTION | ONS (if any): | | 20. MEDICATION P | RESTRICTIONS(if any): |
| limit grip | • • • | | l — | ription medication(s) |
| min grip | | - Add ANGERTAL | ' = ' | |
| | | | | over-the-counter meds |
| | | erstanding of the employee's essential job functions. If a particula | | make drowsy (possible |
| | _ | nodified duty that meets these restrictions is not available, the pat ctions should be followed outside of work as well as at work. | safety/driving is: | sues) |
| silodid be considered to be of | THOIR. NOTE: BICSC TCSS | Citoria ar journe de l'allatte de train de troir de de train. | | |
| PART IV: TREATMEN | IT/FOLLOW-UP AP | POINTMENT INFORMATION | | |
| 21. Work Injury Diagnosi | is Information: 22. | Expected Follow-up Services Include: | | |
| 882.0 Hand Lac W/O Com | | Evaluation by the treating doctor on 09/24/2007 | (date |)at 10:00 am am/pm |
| 002.0 (10.12 200 11.13 20.11 | | | (date | |
| | | Physical medicineX per week forweeks starting | on (date |) atam/pm |
| | | | on (date | |
| | | None. This is the last scheduled visit for this problem. At | this time, no further med | lical care is anticipated |
| Date / Fime of Visit | DYEE'S SIGNATURE | ☐ Initial ☐ | e of Doctor: Designated doctor Corrier selected RME | Treating doctor Referral doctor |
| 09/14/2007 11:49 an | | | Carrier-selected RME DWC-selected RME | ☐ Consulting doctor ☐ Other doctor |
| 98. TTESS 11.74 OH | | <u> </u> | | T Owel operat |

DWC FORM-73 (Rev. 10/05) Page 1



DIVISION OF WORKERS' COMPENSATION

| erviceID: | Concentra Me | | Service Date: |
|--|---------------------------------------|-------------------------------|---|
| ray Number: | Phone: (713) 973-7943 | Fax. (713) 973-7947 | Case Date: |
| Patient: Percy Tostics SSN: Address: | INJURY/ILLNES | S FLOWSHEET | • 12 |
| Home: Work: Ex | · · · · · · · · · · · · · · · · · · · | Sw- | |
| Work: Ext | | C 144 | |
| Cases: | | | |
| Employer Notes | | Protocol Notes | |
| Cut | lift Kind with a | tente while cit | thing tops |
| Injury Flow | | / <u>Time</u> | <u>Mitials</u> |
| Sign-In | | 11.10 | hē |
| Admit | | | |
| - | tion Completed | | |
| I reatme | nt Initiated | | |
| Check O | ut 2:30 H | 4 | |
| Diagnosis Information | | / | |
| 943.02 Burn, Elbow L / R | 923.11 Elbow Contusion L/R | 883.0 Finger Laceration L / F | R 923.21 Wrist Contusion L / R |
| 944.1 Burn, Wr/Hand (1st deg.) | * | | / R 814.00 Wrist Fracture, Closed L / R |
| 944.2 Burn, Wr/Hand (2nd deg.) | | | 719.43 Wrist Pain L / R |
| 354.0 Carpal Tunnel Syndrome (| ' ' ' | 882.0 Hand Laceration L) R | |
| 692.4 Contact Dermatitis (chemic | cal) 923.3 Finger Contusion L / R | - | 727.05 Wrist Tenosynovitis L / R |
| Freating Physician: <u>/≾∕⊘</u> Primary Diagnosis Severity: | Mild Moderate Severe NOF Ot | her Diagnosis: | |
| Activity Status for Upper Ext | | Dates: Anticipated MMI | |
| Restrictions of Primary Ca | | Actual MMI | |
| Regular activity | | Permanent & Sta | itionary |
| Released from care | ~ / A | Remarks: | |
| Modified activity | o aced (O hard | | |
| * | it with limited activity as follows: | - | |
| No repetitive lifting | | Is this case recordable? Y or | N |
| | ing/walking longer than | Medications: | |
| No bending > t | | Dispensed OT | C Prescribed |
| | over fbs of force | - · - | on Tue Wed Thu Fri Sat Sun |
| No reaching above : | | | |
| Keep wound clean a | ınd dry | Date: 19-0 Time: | |
| Must wear sling/bra | ce/splint | Recheck level: 1 2 3 | 4 5 |
| linable to use impas | t tool with rt / left arm / hand | Schedule for therapy time | es per week for weeks |

No activity wsheet - Initial Injury-Upper Extremity

Unable to use impact tool with intilleft, arm / hand

Unable to use power tool with intilleft arm / hand

__Limited use of _____

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Patient is referred to:

Transferred Care

Revision Date: 02/12/2001

Released from Specialist



Fax 713-973-7947

EMPLOYER'S AUTHORIZATION FOR EXAMINATION OR TREATMENT

| Patient Name: PERCY FOSTER Company Name: CES Envisonmental Servi | CCNI |
|--|---|
| Location #/Street Address: 4984 Gariages School, | Howstin Jx 702 Date of Injury: 9-13-07 |
| WORK-RELATED INJURY ILLNESS Post-Aceident Substance Abuse Testing: Drug Screen Breath Alcohol Drug Screen and Breath Alcohol Urine Collection Only DOT Regulated Non-regulated | DOT PHYSICAL Preplacement Recertification Exit Audiogram Regulated Drug Screen Urine Collection Only Breath Alcohol |
| PRE-PLACEMENT EVALUATION Job Title: Physical Exam HPE Regulated Drug Screen Non-regulated Drug Screen Urine Collection Only Hair Collection Audiogram SPECIAL PHYSICAL EXAMINATIONS | SUBSTANCE ABUSE TESTING Regulated Non-regulated Urine Collection Only Rapid Test Pre-placement Reasonable Suspicion Random Periodic Post-accident Follow-up Breath Alcohol |
| AsbestosRespiratorHazmatBaselineOther/ | BILLING Employee to pay charges at time of service Workers' Compensation Insurance Co: Policy #: Phone #: |
| Authorized By: Poblem Plany — Phone: 113-676-1460 (copies of this form available a | Title: 1) SE Manage. Date: 9-13-07 at www.concentra.com) |

DATE/TIME = SEP-13-2007 11:20

JOURNAL No. = 095

COMM. RESULT = OK

PAGE(S) = 001/001

DURATION = 00:00:17

FILE No. = 210

MODE = MEMORY TRANSMISSION

DESTINATION = 7139737947

RECEIVED ID =

RESOLUTION = STD

-CES Environmental Svcs. -

***** DP-3030 ************** - - ***** - 7137488664- ********

To: Prabhakar Thangudu 7136761676

Employee - You are required to report your injury to your employer within 30 days if your employer has workers' compensation insurance. You have the right to free assistance from the Texas Workers' Compensation Commission and may be entitled to certain medical and income benefits. For further information call your local Commission field office or 1 (800):252-7031



Trabajador - Es necesario que usted reporte su lesión a su empleador dentro de 30 días a partir del día en que se lesionó, si su empleador tiene seguro de compensación para trabajadores la Comisión Tejana de Combensación para Trabajadores le ofrece asistencia gratuita, también puede que usted tenga derecho a cierlos beneficios médicos y monetarios. Para mayor información líame a la oficina local de la Comisión 1-800-252-7031.

| _ | TEXAS WORK | ERS' COMPENSATION WORK STAT | US REPORT |
|--|---|--|---|
| PART I: GEN | NERAL INFORMATION | 5. Doctor's Name and Degree Dan P. Browder, MD | (for transmission Date Being Sent purposes only) |
| 1. Injured Employee's | Name | 6. Clinic/Facility Name | 9. Emoloyer's Name |
| Percy Foster | | CMC - Houston I-10 East | CES Environmental |
| 2. Date of Injury 09/13/2007 | Social Security Number (b) (4) | 7. Clinic/Eacility/Doctor Phone & Fax (713)973-7943 (713)973-7947 | 10. Employer's Fax # or Email Address (if known) (713)676-1676 |
| 4. Employee's Descript | | Clinic/Facility/Doctor Acdress (street acdress) | 11. Insurance Carrier |
| Patient states :"Wh a knife while cutting | ile at work I cut my left hand with | 10909 I-10 East Frwy | Texas Mutual Insurance Company |
| a kulle wulle cariluí | g lape. | City St≊te Zio Houston TX 77029 | 12. Carrier's Fax # or Email Address (if known) (512)322-3889 |
| PART II: WOR | K STATUS INFORMATIO | (FULLY COMPLETE ONE INCLUDING ESTIMATED DATES A | AND DESCRIPTION IN 13(c) AS APPLICABLE) |
| 13. The injured of | employee's medical condition re | esulting from the workers' compensation injury: | |
| | | ork as of(date) <u>without restrictions.</u> | |
| I— : : | | ork as of 09/14/2007 (date) with the restrictions in | dentified in PART III, which are |
| | d to last through _09/28/2007 | | |
| | | ployee from returning to work as of | |
| through | (date). The folio | wing describes how this injury prevents the employee | from returning to work: |
| | | | |
| PART III: ACT | TIVITY RESTRICTIONS" (I | REQUIRED IF BOX 13(b) IS CHECKED) | |
| 14 POSTURE I | RESTRICTIONS (if any) : | 17. MOTION RESTRICTIONS (if any): | 19. MISC. RESTRICTIONS (if any): |
| | • | , -, | Max hours per day of work: |
| Max Hours per of Standing | day: 0 2 4 6 8 Other | Max Hours per day: 0 2 4 6 8 Other Walking | Sit/Stretch breaks of per |
| ı - | | | |
| Sitting | | Climbing stairs/ladders | Must wear splint/cast at work |
| Kneeling/Squatt | ing UUUUU | Grasping/Squeezing | Must use crutches at all times |
| Bending/Stoopii | ng 0000 | Wrist flexion/extension | No driving/operating heavy equipment |
| Pushing/Pulling | | Reaching | Can only drive automatic transmission |
| | | | |
| Twisting | <u> </u> | Overhead Reaching | No work/hours/day work: |
| Other: | `` | Keyboarding | in extreme hot/cold environments |
| 15 RESTRICTION | ONS SPECIFIC TO (if applica | hle). Other: | at heights or on scaffolding |
| L Hand/Wri | _ | 18. LIFT/CARRY RESTRICTIONS (if any): | Must keep |
| | | | |
| L Arm | ∐ R Arm ∐ No | | Elevated Clean & Dry |
| ∐ L Leg | ∐R Leg ∐Ba | ack for more thanhours per day | No skin contact with: |
| L Foot/Ankle | e ☐ R Foot/Ankle | May not perform any lifting/carrying | Dressing changes necessary at work |
| Other: | | Other: | No running |
| 16. OTHER RE | STRICTIONS (if any): | <u> </u> | 20. MEDICATION RESTRICTIONS(if any): |
| no use of left har | | | Must take prescription medication(s) |
| 110 400 51 1011 1141 | , | | Advised to take over-the-counter meds |
| | | | |
| | | erstanding of the employee's essential job functions. If a particula nodified duty that meets these restrictions is not available, the pa | |
| | | ictions should be followed outside of work as well as at work. | safety/driving issues) |
| | | | |
| | | PPOINTMENT INFORMATION | |
| 21. Work Injury I | | Expected Follow-up Services Include: | |
| 882.0 Hand Lac | W/O Complication | Evaluation by the treating doctor on 09/14/2007 | (date) at 11:00 am_ am/pm |
| | H | Referral to/Consult withon | (date) at am/pm |
| | H | Physical medicineX per week forweeks starting | |
| | | 1 2 | on (date) at am/pm |
| Date / Torrish (1) | , | None. This is the last scheduled visit for this problem. At | |
| Date / Time of Visit 09/14/2007 09:24 a | EMPLOYEE'S SIGNATURE | | e of Doctor: 💢 Treating doctor Designated doctor 🔲 Referral doctor |
| Discharge Time | † | | Carrier-selected RME Consulting doctor |
| 09/14/2007 09:29 a | n | I II I | DWC-selected RME |
| | - | | |

DWC FORM-73 (Rev. 10/05) Page 1



DIVISION OF WORKERS' COMPENSATION

To: Dan Bowman 7136761676

Employee - You are required to report your injury to your employer within 30 days if your employer has workers' compensation insurance. You have the right to free assistance from the Texas Workers' Compensation Commission and may be ontitled to certain medical and income benefits. For further information call your local Commission field office or 1(800)-252-7031.



TEXAS WORKERS' COMPENSATION WORK STATUS REPORT

Trabajacor - Es necesario que usted reporte su lesión a su empleador dentro de 30 días a partir del día en que se lesionó, si su empleador tiene seguro de compensación para trabajacores. La Comisión Tejana de Compensación para Trabajactores le ofrece asistencia gratuita, lambién puede que usted tenga derecho a ciertos beneficios y monetarios. Para mayor información liame a la oficina local de la Comisión 1-800-252-7031.

| PART I: GENERAL INFORMATION | Dodor's Name and Degree Dan P. Browder, MD | | (for transmission purposes only) | Date Being Sent |
|---|---|-----------------------------|--|------------------------|
| 1. injured Employee's Name | | | 9. Employer's Name | |
| Percy Foster | CMC - Houston I-10 East | | CES Environmental | |
| Date of Injury 3. Social Security Number | 7. Clinic/Facility/Doctor Phone & Fax | | 10. Employer's Fax # or Email A | deress (if known) |
| 09/13/2007 (b) (4) | (713)973-7943 (713)973-79 | 47 | (713)676-1676 | |
| | 8. Clinic/Facility/Doctor Address (street address) | | 11. Insurance Carrier | |
| Patient states: "While at work I cut my left hand with a knife while cutting tape." | 10909 I-10 East Frwy | | Texas Mutual Insurance Cor | |
| , | Gity State Zip Houston TX 77029 | | Carrier's Fax # or Email Ador (512)322-3889 | ess (II MIOWII) |
| | | | | |
| PART II: WORK STATUS INFORMATIO | | | AND DESCRIPTION IN 13(c) | AS APPLICABLE) |
| The injured employee's medical condition reliable (a) will allow the employee to return to we | | | | |
| (b) will allow the employee to return to w | | ne restrictions i | identified in PART III,wh | nich are |
| expected to last through _09/28/2007 | | _ | | |
| (c) has prevented and still prevents the err | | | (date) and is expected to | |
| (date). The folia | and describes now this injury preve | ms the employee | noin returning to work. | |
| Į. | | · | | |
| PART III: ACTIVITY RESTRICTIONS* (I | REQUIRED IF BOX 13(b) IS CHE | CKED) | | |
| 14. POSTURE RESTRICTIONS (if any) : | 17. MOTION RESTRICTIONS (| (if any): | 19. MISC. RESTRIC | :TIONS (if any): |
| Max Hours per day: 0 2 4 6 B Other | Max Hours perday: 0 2 4 | 4 6 B Other | Max hours per o | day of work: |
| Standing | Walking | | Sit/Stretch brea | ks mf ner |
| Sitting | Climbing stairs/ladders | | | |
| | | | Must wear splin | |
| Kneeling/Squatting | _ Grasping/Squeezing LLL | | Must use crutch | es at all times |
| Bending/Stooping | Wrist flexion/extension | <u> </u> | No driving/opera | ating heavy equipment |
| Pushing/Pulling | Reaching | | Can only drive a | automatic transmission |
| Twisting | Overhead Reaching | | ☐ No work/ ☐ _ | hours/day work: |
| Other: | Keyboarding | | | hot/cold environments |
| 15. RESTRICTIONS SPECIFIC TO (if applica | hip). Other: | | | or on scaffolding |
| L Hand/Wrist R Hand/Wrist | 18. LIFT/CARRY RESTRICTIO | NS (if any): | Must keep | |
|][| eck May not lift/carry objects mo | | | |
| | - | | | Clean & Dry |
| | for more thanhours p | | No skin contact | with: |
| L Foot/Ankle R Foot/Ankle | May not perform any lifting/ | carrying | Dressing chang | es necessary at work |
| Other: | Other: | | No running | |
| 16. OTHER RESTRICTIONS (if any): | - · · · · · · · · · · · · · · · · · · · | · | 20. MEDICATION R | ESTRICTIONS(if any): |
| no use of left hand | | | | ription medication(s) |
| | | | | over-the-counter meds |
| *These restrictions are based on the doctor's best und | erstanding of the employee's essential job fi | unctions if a particula | 1 = | make drowsy (possible |
| restriction does not apply, it should be disregarded. If r | | • | tien | |
| should be considered to be off work. Note - these restr | ctions should be followed outside of work a | s well as at work. | safety/driving iss | ues) |
| PART IV: TREATMENT/FOLLOW-UP AF | POINTMENT INFORMATION | | · · · · · · · · | |
| | Expected Follow-up Services Inclu | ıde: | | |
| | Evaluation by the treating doctor on | | (date) | at 11:00 am am/pm |
| 882.0 Hand Lac W/O Complication | Referral to/Consult with | | (date) | |
| <u> </u> | Physical medicineX per week forweeks starting on (date) at am/pm | | | |
| | Special studies (list): | | on (date) | |
| | None. This is the last scheduled visit t | | | _ |
| Date / Time of Visit EMPLOYEE'S SIGNATURE 09/14/2007 09:24 am | DOCTOR'S SIGNATURE | | ile of Doctor: Designated doctor | |
| Discharge Time | 1 | N Initial | Carrier-selected RME | Consulting doctor |
| 09/14/2007 09:29 am | | Follow-up | DWC-selected RME | Other doctor |

DWC FORM-73 (Rev. 10/05) Page 1



DIVISION OF WORKERS' COMPENSATION

Claim Number:

Concentra Medical Centers

10909 I-10 East Frwy Houston, TX 77029 Phone: (713) 973-7943 Fax: (713) 973-7947 **Service Date**: 09/14/2007 **Case Date**: 09/13/2007

Physician Activity Status Report

Patient:
SSN:
Address:
Home:
Work: (713) 672-1700 Ext.:

Employer Location: CES Environmental Address: 4904 Grigas Rd

4904 Griggs Rd Role: DER/Primary

HOUSTON, TX 77021

Phone: (713) 676-1460 Ext.:

Visit Type: Recheck

Contact: Prabhakar Thangudu

Fax: (713) 676-1676

This Visit: Time In: 11:04 am Tim

1:04 am **Time Out**: 11:49 am

Auth. by:

Treating Provider: Jennifer Riggens, PA

Hand Lac W/O Complication

Medications:

Recordable: No

□ Dispensed Prescription Medication to Patient□ Dispensed Over-The-Counter Prescription

☐ Written Prescription given to Patient

Patient Status:

Diagnosis:882.0

Modified Activity - Returning for follow-up visit

Restricted Activity (In effect until next physician visit):

Return to work on 09/14/2007 with the following restrictions Keep wound clean and dry

Remarks:

limit grip

Employer Notice:

The prescribed activity recommendations are suggested guidelines to assist in the patient's treatment and rehabilitation. Your employee has been informed that the activity prescription is expected to be followed at work and away from work.

Anticipated Date of Maximum Medical Improvement: 09/28/2007 Actual Date of Maximum Medical Improvement:

Next Visit(s):

Patient Notice: It is essential to your recovery that you keep your scheduled appointments, but should you need to reschedule or cancel your appointment, please contact the clinic. Thank you for your cooperation.

Visit Date:

Monday September 24, 2007 8:00 am

Provider/Facility: John M. Sanchez, MD

uin 30 days if e the right to free sion and may be entitled information call your local



Trabajador - Es necesario que usted reporte su lesión a su empleador dentro de 30 dias a partir del día en que se lesionó, si su empleador tiene seguro de compensación para trabajadoros. la Comisión Tejana de Compensación para Trabajadores le ofrece asistencia gratuita, también puede que usted tenga derecho a ciertos beneficios médicos y monetarios. Para mayor información liame a la oficina local de la Comisión 1-800-252-7031.

AS WORKERS' COMPENSATION WORK STATUS REPORT (for transmission Date Being Sent INFORMATION Dan P. Browder, MD purposes only) 6. Clinic/Facility Name 9. Employer's Name CMC - Houston I-10 East **CES** Environmental or Injury 7. Clinic/Facility/Doctor Phone & Fax 10. Employer's Fax # or Email Address (if known) (713)973-7947 (713)676-1676 09/13/2007 (713)973-7943 Employee's Description of Injury/Accident Clinic/Facility/Doctor Address (street address) Patient states: "While at work I cut my left hand with 10909 I-10 East Frwy Texas Mutual Insurance Company a knife while cutting tage. 12. Carrier's Fax # or Email Address (if known) TX Houston (512)322-3889 PART II: WORK STATUS INFORMATION (FULLY COMPLETE ONE INCLUDING ESTIMATED DATES AND DESCRIPTION IN 13(c) AS APPLICABLE) The injured employee's medical condition resulting from the workers' compensation injury: (date) without restrictions. __(a) will allow the employee to return to work as of _ X (b) will allow the employee to return to work as of 09/14/2007 (date) with the restrictions identified in PART III, which are expected to last through 09/28/2007 (date). has prevented and still prevents the employee from returning to work as of (date) and is expected to continue _(date). The following describes how this injury prevents the employee from returning to work: PART III: ACTIVITY RESTRICTIONS* (REQUIRED IF BOX 13(b) IS CHECKED) 19. MISC. RESTRICTIONS (if any): 14. POSTURE RESTRICTIONS (if any) : 17. MOTION RESTRICTIONS (if any): Max hours per day of work: Max Hours per day: 0 2 4 6 8 Other Max Hours per day: 0 2 4 6 8 Other Walking Standing Sit/Stretch breaks of ____ Sitting Climbing stairs/ladders Must wear splint/cast at work Kneeling/Squatting Grasping/Squeezing Must use crutches at all times Bending/Stooping Wrist flexion/extension No driving/operating heavy equipment Pushing/Pulling Can only drive automatic transmission Reaching Twisting Overhead Reaching No work/ ____hours/day work: Other: Keyboarding in extreme hot/cold environments Other: at heights or on scaffolding 15. RESTRICTIONS SPECIFIC TO (if applicable): 18. LIFT/CARRY RESTRICTIONS (if any): X Must keep wound L Hand/Wrist R Hand/Wrist May not lift/carry objects more than Neck ☐ Elevated X Clean & Dry L. Arm L Leg R Leg Back for more than ____hours per day No skin contact with:_ May not perform any lifting/carrying L Foot/Ankle R Foot/Ankle Dressing changes necessary at work Other:_ No running 16. OTHER RESTRICTIONS (if any): 20. MEDICATION RESTRICTIONS(if any): limit grip Must take prescription medication(s) Advised to take over-the-counter meds These restrictions are based on the doctor's best understanding of the employee's essential job functions. If a particular Medication may make drowsy (possible restriction does not apply, it should be disregarded. If modified duty that meets these restrictions is not available, the patient safety/driving issues) should be considered to be off work. Note - these restrictions should be followed outside of work as well as at work PART IV: TREATMENT/FOLLOW-UP APPOINTMENT INFORMATION 21. Work Injury Diagnosis Information: 22. Expected Follow-up Services Include: Evaluation by the treating doctor on 09/24/2007 (date) at 10:00 am am/pm 882.0 Hand Lac W/O Complication Referral to/Consult with Physical medicine ____X per week for ___weeks starting on _ Special studies (list): ___ (date) at_ ☐ None. This is the last scheduled visit for this problem. At this time, no further medical care is anticipated Date / Time of Visit **EMPLOYEE'S SIGNATURE** DOCTOR'S SIGNATURE Visit Type: Role of Doctor: Treating doctor

DWC FORM-73 (Rev. 10/05) Page 1

09/14/2007 11:04 am

09/14/2007 11:49 am

Discharge Time



DIVISION OF WORKERS' COMPENSATION

Designated doctor

☐ Carrier-selected RME

DWC-selected RME

Initial

Follow-up

Referral doctor

Other doctor

Consulting doctor

Employee - You are required to report your injury to your employer within 30 days if your employer has workers' compensation insurance. You have the right to free assistance from the Texas Workers' Compensation Commission and may be entitled to certain medical and income penefits. For further information call your local Commission field office or 1(800):252-7031.



Trabajador - Es nocesario que usied reporte su lesión a su empleador dentro de 30 días a partir del día en que se tesiono, si su empleador tene seguro de compensación para trabajadores. la Comisión Tejana de Compensación para Trabajadores le ofrece asistencia gratuita, también puede que usied tenga derecho a cienos beneficios médioos y monetanos. Para mayor información líame a la oficina local de la Comisión 1-800-252-7031.

| TEXAS WORK | ERS' COMPENSATION WORK STAT | TUS REPORT |
|--|---|---|
| PART I: GENERAL INFORMATION | 5. Doctor's Name and Degree Dan P. Browder, MD | (for transmission Date Being Sent |
| | 6. Clinic/Facility Name | 9. Employer's Name |
| Percy Foster | CMC - Houston I-10 East | CES Environmental |
| Date of Injury 3, Social Security Number | 7. Clinic/Facility/Doctor Phone & Fax | 10. Employer's Fax # or Email Address (if known) |
| 09/13/2007 (D) (4) | (713)973-7943 (713)973-7947 | (713)676-1676 |
| | Clinic/Facility/Doctor Address (street address) | 11. Insurance Carrier |
| Patient states :"While at work I cut my left hand with a knife while cutting tape." | 10909 I-10 East Frwy | Texas Mutual Insurance Company |
| • . | City State Zip Houston TX 77029 | 12. Carrier's Fax # or Email Address (if known) (512)322-3889 |
| PART II: WORK STATUS INFORMATION | (FULLY COMPLETE ONE INCLUDING ESTIMATED DATES | S AND DESCRIPTION IN 13(c) AS APPLICABLE) |
| 13. The injured employee's medical condition re (a) will allow the employee to return to w X (b) will allow the employee to return to w expected to last through 09/28/2007 (c) has prevented and still prevents the em | esulting from the workers' compensation injury: ork as of(date) without restrictions. | identified in PART III, which are _(date) and is expected to continue |
| PART III: ACTIVITY RESTRICTIONS* (F | REQUIRED IF BOX 13(b) IS CHECKED) | |
| 14. POSTURE RESTRICTIONS (if any) : | 17. MOTION RESTRICTIONS (if any): | 19. MISC. RESTRICTIONS (if any): |
| , | ` '' | Max hours per day of work: |
| Max Hours per day: 0 2 4 6 8 Other | Max Hours per day: 0 2 4 6 8 Other | That hours per day or norm. |
| Standing | Walking UUUU | Sit/Stretch breaks ofper |
| Sitting | Climbing stairs/ladders 🔲 🔲 🔲 🔲 📗 | Must wear splint/cast at work |
| Kneeling/Squatting | Grasping/Squeezing | Must use crutches at all times |
| | Wrist flexion/extension | |
| Bending/Stooping | | No driving/operating heavy equipment |
| Pushing/Pulling | Reaching | Caπ only drive automatic transmission |
| Twisting | Overhead Reaching | No work/ hours/day work: |
| Other: | Keyboarding | in extreme hot/cold environments |
| | <u> </u> | |
| 15. RESTRICTIONS SPECIFIC TO (If applica | | at heights or on scaffolding |
| L Hand/Wrist R Hand/Wrist | 18. LIFT/CARRY RESTRICTIONS (if any): | X Must keep wound |
| □LArm □RArm □Ne | eck May not lift/carry objects more thanlbs | Elevated X Clean & Dry |
| ∏L Leg ∏B Leg ∏Ba | for more thanhours per day | No skin contact with: |
| | | |
| L Foot/Ankle R Foot/Ankle | May not perform any lifting/carrying | Dressing changes necessary at work |
| Other: | Other: | ☐ No running |
| 16. OTHER RESTRICTIONS (if any): | | 20. MEDICATION RESTRICTIONS(if any): |
| limit grip | | Must take prescription medication(s) |
| | | Advised to take over-the-counter meds |
| *These restrictions are based on the doctor's best und | erstanding of the employee's essential job functions. If a particu | lar Medication may make drowsy (possible) |
| | nodified duty that meets these restrictions is not available, the p | patient |
| should be considered to be off work. Note - these restr | ctions should be followed outside of work as well as at work, | safety/driving issues) |
| PART IV: TREATMENT/FOLLOW-UP AF | POINTMENT INFORMATION | |
| | Expected Follow-up Services Include: | |
| TX | Evaluation by the treating doctor on 09/24/2007 | (date) at 10:00 am am/pm |
| 882.0 Hand Lac W/O Complication | Referral to/Consult with on | (date) atam/pm |
| | Physical medicineX per week forweeks starting | · , , _ |
| | Special studies (list): | on (date) at am/pm |
| | None. This is the last scheduled visit for this problem. | |
| Date / Time of Visit EMPLOYEE'S SIGNATURE | | ole of Doctor: X Treating doctor |
| 09/14/2007 11:04 an | Initial | Designated doctor Referral doctor |
| Discharge Time | ⊠ Follow-up | Carrier-selected RME Consulting doctor |
| 09/14/2007 11:49 am | ST LOUGH-OH | DWC-selected RME Other doctor |

DWC FORM-73 (Rev. 10/05) Page 1



DIVISION OF WORKERS' COMPENSATION

Joe Hernanoez Accessent 9-7-07

EPAHO043000087

CES Environmental Services, Inc.

4904 Griggs Road Houston, TX 77021 Phone: (713) 676-1460 Fax: (713) 676-1676

Fax

| To: | From: | Prabhakar R. Thangudu |
|---|--------|---|
| Reba/Kim | | (b) (4) |
| Fax: 713-973-7947 | Pages: | 7 |
| Phone: | Date: | 9-7-07 |
| Reba: Here is the author Please call me if yo | | be Joseph Hermandez. any questions. Thanks, Rothan |
| | | |

******* -IND. XMT JOURNAL- ********** DATE SEP-07-2007 **** TIME 08:38 *******

DATE/TIME = SEP-07-2007 08:23

JOURNAL No. = 015

COMM. RESULT = OK

PAGE(S) = 002

DURATION = 00:00:20

FILE No.

= 131

MODE

= MEMORY TRANSMISSION

DESTINATION = 7139737947

RECEIVED ID =

RESOLUTION = STD

-CES Environmental Svcs. -

***** DP-3030 ***********

_ **** _

7137488664- *******

Rec'd 2-25-08



AIG Domestic Claims, Inc. Property/Casualty Division

P.O. Box 25588

Shawnee Mission, KS 66225

(800) 242-2987

(all other) Fax (866) 723-0109 (new losses) Fax (866) 854-4926

AUTOMOBILE LIABILITY CLOSED CLAIM NOTICE

February 20, 2008

CES ENVIRONMENTAL SERVICES INC

4904 GRIGGS ROAD

HOUSTON, TX 77021-0000 Attn: CARL GUIDRY

RE: Insured

: CES ENVIRONMENTAL SERVICES INC

Carrier Date of Loss : Commerce & Industry

Claim Number

+ 09/0**7**/2007 (b) (4)

Date Reported

: 09/07/2007

Date Received

: 09/07/2007

The above captioned claim has been closed. The following are usus were paid on the claim:

Symbol Claimant
001 CHISA BLOOMER
002 CES ENVIRONMENTAL

MJC Indemnity 007 \$3,748.55

Medical

Legal \$100.94

009 \$4.863,57

\$263.37

003 CHISA BLOOMER 006

ADDITIONAL CLAIM INFORMATION:

Policy Number : 005062132

Loss Location : 2000 MARKET ST HOUSTON,TX

Description of Loss ∴ W MADE ILLEGAL TURN FROM WRONG LANE STRUCK OV ON PASSENGER

SIDE

Insured Driver : HERNANDEZ JOSEPH

RISK ANALYSIS INFORMATION:

| Level I: | } | | | |
|----------|---|------|------|--|
| Level 2: | | | | |
| Level 3: | | | | |
| Level 4: | | | | |
| Leve(5: | | | | |
| Level 6: | | | | |

Thank you for allowing us to serve you on this claim. Please contact me if you have any questions or comments.

Sincerely.

EUPHAS KINYAR EASTIBATI CLAIMIREP 251-PC OVERTAND PARK, KS

(913) 338-9206

ELPHAS.KINYAE@AIG.COM

Origina.

RECEIVED

FEB 2 5 2008

BY:



INCIDENT REPORT

| Near Miss | Accident XXX |
|---|--|
| Date of Incident <u>09/07/2007</u> Time <u>7:30 am</u> | <u>1</u> |
| Result of Incident: No Injuries to Any F | Party |
| 1) □Fire 2) □ Explosion 3) XXX Equipm 5) □ Product Loss 6) □ Production Loss 7 8) □ Other | XXX Employee Endangerment |
| Person(s) Directly Involved | |
| Name: Joseph Hernandez | Name: Chisa Bloomer |
| Name: Michael Bloomer | Name: Aniya Arroyo |
| Exact Location Where Incident Occurred: 12800 | Market Street |
| Describe Fully How Incident Occurred: Stateme | ent of Joseph Hernandez; I was traveling |
| eastbound on Market when I realized that I need | ed to turn around. I was in the right lane and I |
| turned to the left. I did not see the car on the sid | le of me. I hit the car on the passenger side. 1 |
| immediately stopped and rushed to the car to ma | ake sure everyone was all right. The police were |
| called and I told them what happened. I receive | d a ticket for illegal turn from the wrong lane. |
| | |

Recommendations to Prevent Reoccurrence: <u>Immediate reassignment of the driver pending final</u> outcome of the investigation. Driver should remain reassigned until all police reports, D.O.T. documentation and drug screen results are received by CES Environmental, Inc.

What Unsafe Acts/Conditions Lead to Incident: Driver did not verify clearance to change lanes

properly before attempting a left turn from the right lane of traffic.



HPD Unit 9C44D was dispatched to the scene. The HPD Officer at the scene informed CES HSE Manager Karl Guidry that the official report will be written to indicate no injury to any person(s). The HPD Officer stated he repeatedly asked the driver of the car if she or her kids were injured or in need of an ambulance. The HPD Officer stated the driver told him she and her kids were okay and did not require an ambulance.

Joseph Hernandez was cited by Houston Police Department for illegal turn from the wrong lane.

CES EHS Manager Karl Guidry escorted Joseph Hernandez from the accident site to Concentra

Labs at 10969 I-10 East, Houston, Texas 77029, to have him tested for drugs and alcohol.

Concentra personnel provided CES people with a Federal Drug Testing Custody and Control

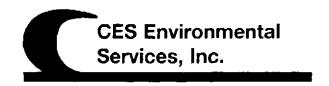
Form 23172258 (attached) and indicated drug test results will be available and sent to CES in two days.

Damage estimates are unknown at this time. Alliana Insurance was notified and given the accident information on September 7, 2007 by CES HSE Manager Karl Guidry

| Witnesses: Name: NONE | Name | |
|--------------------------------|--------------------------------------|------------|
| Name | Name | _ |
| Prepared by: Karl A. Guidry | Title: CES Environmental EHS Manager | Initials A |
| Approved by: Steve Stricker | Title: Vice President | Initials |
| Safety Representative Notified | (Name) Karl A. Guidry | |



EMPLOYER'S AUTHORIZATION FOR EXAMINATION OR TREATMENT (MUST PRESENT PHOTO ID AT TIME OF SERVICE) Patient Name: Hen mondes Justinh Company Name: CES E in the invented San are by Location #/Street Address: 4年4 日本海 尼北山 井山石本 7762) Date of Injury: ___ #5 #7 INJURY ILLNESS WORK-RELATED DOT PHYSICAL Post-Accident Substance Abuse Testing ____ Preplacement ___ Drug Screen Aim # Recertification ____Exit 1-800-247-298-13-13-16-XT ____ Audiogram Ret Insurana Altona ___ Urii Bra 713- 966-1794 ELPHAS KINYAE SUBSTAN ___Rec No. Property & Burn & Barry Urir William to the Rail Pre Rea Rar 1 Bedrick Colors Pos 1-518 347-13 Em Workers' Compensation Insurance Co: Policy #: _____ Phone #: ___ Title: 11SE MEDICE Date: <u>9-7-77</u> Phone: 713-676-1460 (copies of this form available at www.concentra.com)



INCIDENT REPORT

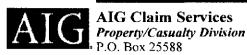
| Near Wilss | Accident AXA |
|--|--|
| Date of Incident <u>09/07/2007</u> Time <u>7:30 am</u> | |
| Result of Incident: No Injuries to Any Party | |
| 1) ☐ Fire 2) ☐ Explosion 3) XXX Equipment Dan 5) ☐ Product Loss 6) ☐ Production Loss 7) XXX E 8) ☐ Other | mployee Endangerment |
| Person(s) Directly Involved | |
| Name: Joseph Hernandez Name: G | Chisa Bloomer |
| Name: Michael Bloomer Name: A | Aniya Arroyo |
| Exact Location Where Incident Occurred: 12800 Market | Street |
| Describe Fully How Incident Occurred: Statement of Jose eastbound on Market when I realized that I needed to turn turned to the left. I did not see the car on the side of me. immediately stopped and rushed to the car to make surce called and I told them what happened. I received a ticket | n around. I was in the right lane and I I hit the car on the passenger side. I everyone was all right. The police were |
| What Unsafe Acts/Conditions Lead to Incident: <u>Driver di</u> properly before attempting a left turn from the right lane | |
| Recommendations to Prevent Reoccurrence: <u>Immediate r</u> | eassignment of the driver pending final |
| outcome of the investigation. Driver should remain reass | signed until all police reports, D.O.T. |
| documentation and drug screen results are received by CI | ES Environmental, Inc. |

HPD Unit 9C44D was dispatched to the scene. The HPD Officer at the scene informed CES HSF Manager Karl Guidry that the official report will be written to indicate no injury to any person(s). The HPD Officer stated he repeatedly asked the driver of the car if she or her kids were injured or in need of an ambulance. The HPD Officer stated the driver told him she and her kids were okay and did not require an ambulance.

Joseph Hernandez was cited by Houston Police Department for illegal turn from the wrong lanc. CES EHS Manager Karl Guidry escorted Joseph Hernandez from the accident site to Concentra Labs at 10969 I-10 East, Houston, Texas 77029, to have him tested for drugs and alcohol. Concentra personnel provided CES people with a Federal Drug Testing Custody and Control Form 23172258 (attached) and indicated drug test results will be available and sent to CES in two days.

Damage estimates are unknown at this time. Alliana Insurance was notified and given the accident information on September 7, 2007 by CES HSE Manager Karl Guidry

| Witnesses: Name: <u>NONE</u> | Name | _ |
|--------------------------------|--------------------------------------|------------|
| Name | Name | |
| Prepared by: Karl A. Guidry | Title: CES Environmental EHS Manager | Initials 4 |
| • • • | | Initials |
| Safety Representative Notified | (Name) Karl A. Guidry | |



Shawnee Mission, KS 66225 (800) 242-2987

(all other) Fax (866) 723-0109 (new losses) Fax (866) 854-4926

64

AUTOMOBILE LIABILITY **NEW CLAIM ACKNOWLEDGEMENT**

September 11, 2007

CES ENVIRONMENTAL SERVICES INC 4904 GRIGGS ROAD HOUSTON, TX 77021-0000

Attn: CARL GUIDRY

RE: Insured

: CES ENVIRONMENTAL SERVICES INC

Carrier

: Commerce & Industry

Date of Loss

: 09/07/2007

Date Reported

: 09/07/2007

Claim Number

(b) (4)

Date Received

: 09/07/2007

This letter will confirm receipt of the above referenced claim.

ADDITIONAL CLAIM INFORMATION:

Policy Number

: 005062132

Loss Location

: 12000 MARKET ST HOUSTON,TX

Description of Loss

: IV MADE ILLEGAL TURN FROM WRONG LANE STRUCK OV ON PASSENGER

Insured Driver

: HERNANDEZ JOSEPH

RISK ANALYSIS INFORMATION:

| MOIL AIME LOID HILL | /ICIVIZA 3 IC/IV | | | |
|---------------------|------------------|------|------|--|
| REGION: | | | | |
| LOCATION: | | | | |
| SHELTER DIV: | | | | |
| SECTION: | | | | |
| LEVEL 5: | | | | |
| LEVEL 6: | | | | |

CLAIMANT INFORMATION:

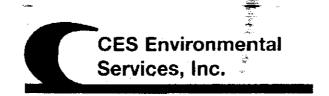
Symbol Name 001 CHISA BLOOMER MJC

007

002 **CES ENVIRONMENTAL** 009

If you have any comments or questions, please feel free to contact me. Kindly refer to the above claim number on any correspondence.

Sincerely, **ELPHAS KINYAE** FAST TRACK CLAIM REP 251-PC OVERLAND PARK, KS (913) 338-9206 ELPHAS.KINYAE@AIG.COM Original



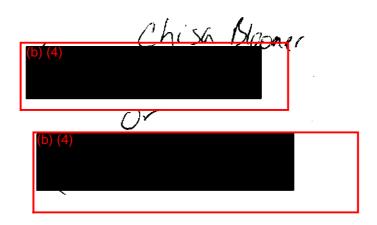
INCIDENT REPORT

| Near Miss Acci | dent | Equipment Damage XX | ΚX |
|---|--------------------|--------------------------|----------|
| Date of Incident Time ターフータフ Result of Incident: <u>Dam</u> | e age to CES Eq | <u>uipment</u> | |
| 1) □ Fire 2) □ Explosic 5) □ Product Loss 6) □ □ 8) □ Other | Production Loss 7 | 7) Employee Endangerment | y Damage |
| Person(s) Directly Involved: | | | |
| Name: Toe Hernan | der Name: | | |
| Exact Location Where Inciden | t Occurred: | | |
| Describe Fully How Incident (| Occurred: | | c = N = |
| Describe Fully How Incident (103 Involved in | accident | with 2nd i | rehiele |
| What Unsafe Acts/Conditions | | | |
| Recommendations to Prevent | Reoccurrence: | | |
| Damage estimates are ~ \$979 | 38.0 | | |
| Witnesses: Name: | Name | | |
| Name | Name | · . | |
| Prepared by: Karl A. Guidry | Title: CES Env | vironmental EHS Manager | Initials |
| Approved by: Steve Stricker | Title: Vice Pre | esident | Initials |



Karl Guidry HSE Manager

Office: (713) 676-1460
Fax: (713) 676-1676
4904 Griggs Rd.
Houston, ITX 77021 Email: leguidry@cesenvironmental.com



Insurana Alliana Chad 713-966-1796

Driver's Name Joseph Hernmorz Vehicle # 103
Descript Details of accident
[Beaner George]

| HOUS | TON POLICE DEPARTMENT |
|----------------------------------|---------------------------|
| | 132026507 S R ACCIDENT |
| Address / | 800 MARKET |
| Date <u>9-7</u> Officer's Nam | ne CR LAGROUE |
| Unit No. 9 | CYYD |



EMPLOYER'S AUTHORIZATION FOR EXAMINATION OR TREATMENT

| Patient Name: Hernandez/ Joseph Company Name: CES Environmental Services, Location #/Street Address: 4904 Griogs Road, House Temporary Staffing Agency: - NA - WORK-RELATED INJURY ILLNESS Post-Accident Substance Abuse Testing: | SSN: (b) (4) Date of Birth: (b) (4) |
|---|---|
| DOT Regulated Non-regulated | Breath Alcohol |
| PRE-PLACEMENT EVALUATION Job Title: Physical Exam HPE Regulated Drug Screen Non-regulated Drug Screen Urine Collection Only Hair Collection Audiogram | SUBSTANCE ABUSE TESTING Regulated Non-regulated Urine Collection Only Rapid Test Pre-placement Reasonable Suspicion Random Periodic Post-accident Follow-up |
| SPECIAL PHYSICAL EXAMINATIONS Asbestos Respirator Hazmat Baseline Other | Breath Alcohol BILLING Employee to pay charges at time of service Workers' Compensation Insurance Co: Policy #: Phone #: |
| Authorized By: Polhon/Claux A Phone: | Title:HSE Mavage |

SPECIMEN ID NO.

23172258

10101 Renner Blvd • Lenexa, KS 66219 (800) 728-4064 for Client Services

[LabOne]

in the second of

B. MRO Name, Address, Phone and Fax No.

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

Signature of Medical Review Officer

| A. Employer Name, Addr | | | | | 102.012 | O A BARDS | |
|--|--|--|--|--|--|--|--|
| - 1995年 - 1997年1月1日 - 1996年 - 1997年 - | | | | | 27, 231, 83 | ¥er Kaliki Sirava. | No. 1995 Marie - Wassi |
| A GOLDEN | TH 77 0 23 | i e | | | / 3 40 (1) | i lista 3t Land fan | i Paris Samani Paris Maria Samani |
| 11/1924622/1925 | 78: 73 5-633 | 1442 | | | F41 - 4 | | A Line of the second of the se |
| | (b) (4) | | | | | | |
| C. Donor SSN or Employ | oo I D No | | | | | ď | |
| _ · · · · · | Pre-employment | Random | □ Bose | onable Suspicion/ | Carre | Post Acciden | nt . |
| D. Peason for lest. | Return to Duty | _ | | Other (specify) | Oduse | ET Oat Acoiden | |
| E. Drug Tests to be Perfo F. Collection Site Address | rmed: 🗆 THC, C | OC, PCP, OPI, A | · | & COC Only | Other | (specify) | |
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| <i>y</i> . | Augustus (S. 1994) | | Col | lector Fax No. | 2000 | 17-5 719. | · / |
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| between 90° and 100° F | | | | | ne Provide | d (Enter Remark) | Observed (Enter Remark) |
| | <u> </u> | | | | | | |
| REMARKS | | | | | | | |
| STEP 3: Collector affixes bott STEP 4: CHAIN OF CUSTO | | | | | | EP 5 on Copy 2 (MRC | O Copy) |
| I certify that the specimen given | to me by the donor ident | ********** | | | | peled, sealed and releas | sed to the Delivery Service noted in |
| accordance with applicable Fed | Y | <i>†</i> ; | . AM | SPECIMEN B | OTTLE(S |) RELEASED TO: | |
| Signature | of Collector | Time of | Collection AM | | | | |
| | | | lo/Day/Yr.) • | | | All L | Beller E. |
| (PAINT) Collector's | Name (First, MI, Last) | Date (M | lo./Day/Yr.) | | Name of Deli | very Service Transferring S | specimen to Lab |
| | | | | | | 4 | 101 |
| RECEIVED AT LAB: | | | | Primary Spe | | SPECIMEN BOTT | LE(S) RELEASED TO: |
| RECEIVED AT LAB: | | | ► | Primary Spe Bottle Seal | | SPECIMEN BOTT | LE(S) RELEASED TO: |
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(PRINT) Medical Review Officer's Name (First, MI, Last)

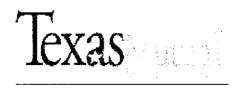
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Date (Mo./Day/Yr.)

EPAHO043000104

Moises Raminez Calderon Accident

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10/10/2007

C E S ENVIRONMENTAL SERVICES I 4904 GRIGGS RD HOUSTON TX 77021-3208



Notification Confirming Receipt of Claim

Date of Injury: 10/03/2007

Injured Worker: CALDERMON, MOISES R

Claim Number: (b) (4)
Policy Number: 0001086044

Attached is a copy of the information you reported to Texas Mutual Insurance Company which was used to establish this claim. You may submit additional claim information to Texas Mutual Insurance Company. If you have questions regarding this report of injury please contact us at (800) 859-5995.

If your policy includes our workers' compensation health care network option you are required by law to obtain a second Employee Acknowledgement of Workers' Compensation Network Form signed by the injured worker. Please submit a copy of the signed, second acknowledgement form to Texas Mutual Insurance Company. You can find a copy of the form online at www.texasmutual.com/hcn/hcn.shtm

Below please find information that will help you through the claim process:

To submit additional claim information:

Mail to: P. O. Box 12029

Austin, Texas 78711-2029 Fax to: (512) 224-3889 To locate a treating doctor:

www.texasmutual.com/workers/iwADL.shtm

To contact the handling adjuster:

Call: (800) 859-5995

Monday - Friday; 8:00 a.m. - 5:30 p.m.

To obtain a copy of the Employer and Employee Rights and Responsibilities in the

Workers' Compensation System:

www.texasmutual.com/employers/erRights.shtm

To locate a pharmacy, or for pharmacy questions, contact Scripnet

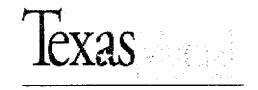
Call: (800) 880-8562 www.scripnet.com

To obtain a copy of the Employer and Employee Rights and Responsibilities for the workers' comp health care network:

www.texasmutual.com/hcn/hcn.shtm

Additional Texas Mutual® online services at www.texasmutual.com, available 6 a.m. - 9 p.m., include:

- o Obtain logon id, or for immediate logon id, call (800) 859-5995. M-F, 8:00 a.m. 5:30 p.m.
- o Submit first report of injury in the Employers section
- o Submit wage statement when reviewing loss runs and claim details
- o Obtain specific claim summary information



Claim Number: 99H0000506791

Notification Date: 10/09/2007

EMPLOYED'S FIRST DEPORT OF INTURY

| EMILOTER STIRST REPORT OF INJURY | | | | | | |
|---|--|--|--|--|--|--|
| <u>INJURED EMPLOYEE</u> | BUSINESS/EMPLOYER | | | | | |
| Name: MOISES R CALDERMON SSN: XXX-XX(b) Mailing Address: (b) (4) | Name: C E S ENVIRONMENTAL SERVICES I Address: 4904 GRIGGS RD HOUSTON TX 77021-3208 | | | | | |
| County: | Phone: (713)676-1460 Ext: Fax: (713)676-1676 | | | | | |
| Physical | Policy Number: 0001086044 | | | | | |
| Address: | FEIN: 760592985 | | | | | |
| County: | Location ID: | | | | | |
| | <u>EMPLOYMENT</u> | | | | | |
| Home Phone: Date of Birth: Marital Status: Manied Gender: Language: English MEDICAL PROVIDER | Occupation: HELPER Hire Date: (b) (4) Partner/Officer/Owner: No Date Lost Time Began: 00/00/0000 Return to Work Date: Last Paycheck was: (b) (4) Wage: Frequency: Hourly | | | | | |
| Name: | Frequency: Hourty | | | | | |
| Tax ID: | Hours/Week: Days/Week: | | | | | |
| Address: | Period Start: 00/00/0000 Period End: 00/00/0000 Supervisor Name: MARLIN | | | | | |
| Phone: Ext: Fax: | Phone: Ext: | | | | | |
| | PREPARER OF REPORT | | | | | |
| <u>ATTORNEY</u> | Name: PRABHAKAR THANGUDU | | | | | |
| Represented by Attorney: Name: Phone: | Name: PRABHAKAR THANGUDU Phone: (713)676-1460 Ext: Fax: Email: | | | | | |
| | FORMATION | | | | | |
| Date of Injury: 10/03/2007 Time: 04:00 | Address Where Injury Occurred: 4904 GRIGGS RD | | | | | |
| Date Reported: 10/03/2007 Nature of Injury: UNKNOWN/NOT REPORTED | HOUSTON TX 77021 | | | | | |
| Cause of Injury: FALL/SLIP OR TRIP INJURY-ON SAME LEVEL | County: HARRIS Witnesses: Name: | | | | | |
| Part of Body: SOFT TISSUE | Phone: Name: Phone: | | | | | |

Name:

Phone:

How and Why the Injury/Illness Occurred HEAD: HIT HARD AGAINST THE.

No

Fatality:

C E S ENVIRONMENTAL SERVICES I 4904 GRIGGS RD HOUSTON TX 77021-3208

CES Environmental Services, Inc.

Referred with bills on

4904 Griggs Road Houston, TX 77021 Phone: (713) 676-1460 Fax: (713) 676-1676

Fax

| To: Latonica N. Ray | From: | Prabhakar R. Thangudu (b) (4) |
|---------------------|--------|--------------------------------|
| Fax: 512-224-3887 | Pages: | 3 |
| Phone: | Date: | 10-09-2007 |

Ms. Ray:

Moises Raminez CALDERON

55# (6)(4)

DWC Form I

I will appreciate receiving a Carriers

Claim Number for this case. Please let me Know

if you need additional information.

Thanks,

Poullaborthaged

Send the specified copies to your Workers' Compensation Insurance Carrier and the injured employee. *Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, CLAIM# Unless the Division specifically requests a direct filling. CARRIER'S CLAIM # EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS 15. Date of Injury (m-d-y) 16. Time of Injury 17. Date Lost Time Began 1 Name (Last First M.I.) 2. Sex _F□ _M⊡∕ Coldenon Musses 4 70 am 17 pm 11 t3-Zu1 18. Nature of Injury* 19. Part of Body Injured or Exposed* Fall from laddon ricad 20. How and Why Injury/Illness Occurred* Does the Employee Speak English? If No. Specify Language Hit head against the flows YES 🗂 ио □ 21. Was employee doing his YES regular job? NO 22. Worksite Location of Injury (stairs, dock, etc.)* 7. Race 8. Ethnicity Hispanic 🖃 White W. TUNCISE Black Asian D Native American 🔲 Other 🗖 23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site Zip Code County Street or P.O. Box Zip Code 7.7(2) State HEUSTON Single Divorced D Married 🖾 Widowed 🔲 Separated 🔲 24. Cause of Injury(fall, tool, machine, etc.)* 11. Number of Dependent Children ANA HEREDIA Fall 25. List Witnesses 13. Doctor's Name 27. Did employee 14. Doctor's Mailing Address (Street or P.O.Box) 26. Return to work 28. Supervisor's 29. Date Reported date/or expected Name die? (m-d-y) (m-d-y) Marlin City Zip Code YES 🗖 NO 🌠 16-60-2661 Missix -(4-207 31. Was employee hired or recruited in Texas? 30 Date of Hire (m-d-v) 32. Length of Service in Current Position 33. Length of Service in Occupation YES 🗹 NO 🗖 Years Z Months 🚣 🛭 Years Months 35. Occupation of Injured Worker 34. Employee Payroll Classification Code HELPER 36. Rate of Pay at this Job 37. Full Work Week is 38. Last Paycheck was: 39. Is employee an Owner, Partner, or Corporate Officer? \$ 10 Hourly \$_ \$<u>878</u> for <u>**6**1 Hours or_</u> _Weekly 40 Hours 40. Name and Title of Person Completing Form CES Envisionmental Services, Phabhakas R. Thangudu HSE MANAGEL 42. Business Mailing Address and Telephone Number Street or P.O. Box 43. Business Location (If different from mailing address) Telephone Number and Street 4464 Griggs Read (7/3) 676-1460 City Zip Code State Zip Code Houston 77021 44. Federal Tax Identification Number 45. Primary North American Industry Classification System 46. Specific NAICS Code 47. Texas Comptroller Taxpayer No. Code:(8 digit) (6 digit) 562719 362.219 17605929364 76-0592985 48. Workers' Compensation Insurance Company 49. Policy Number TEXAS MUTUAL TSF 000 1886044 50. Did you request accident prevention services in past 12 months? YES 🗹 YES ☑ NO ☐ If yes, did you receive them? YES ☑ NO☐

51. Sign#qure and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING) YES NO

DWC FORM-1 (Rev. 10/05) Page 3

|| **|| || || || || ||** || || ||

Date 11 18-200 1

Employee Acknowledgment of Workers' Compensation Network

I have received information that tells me how to get health care under my employer's workers' compensation insurance.

If I am hurt on the job and live in a service area described in this information, Lunderstand that:

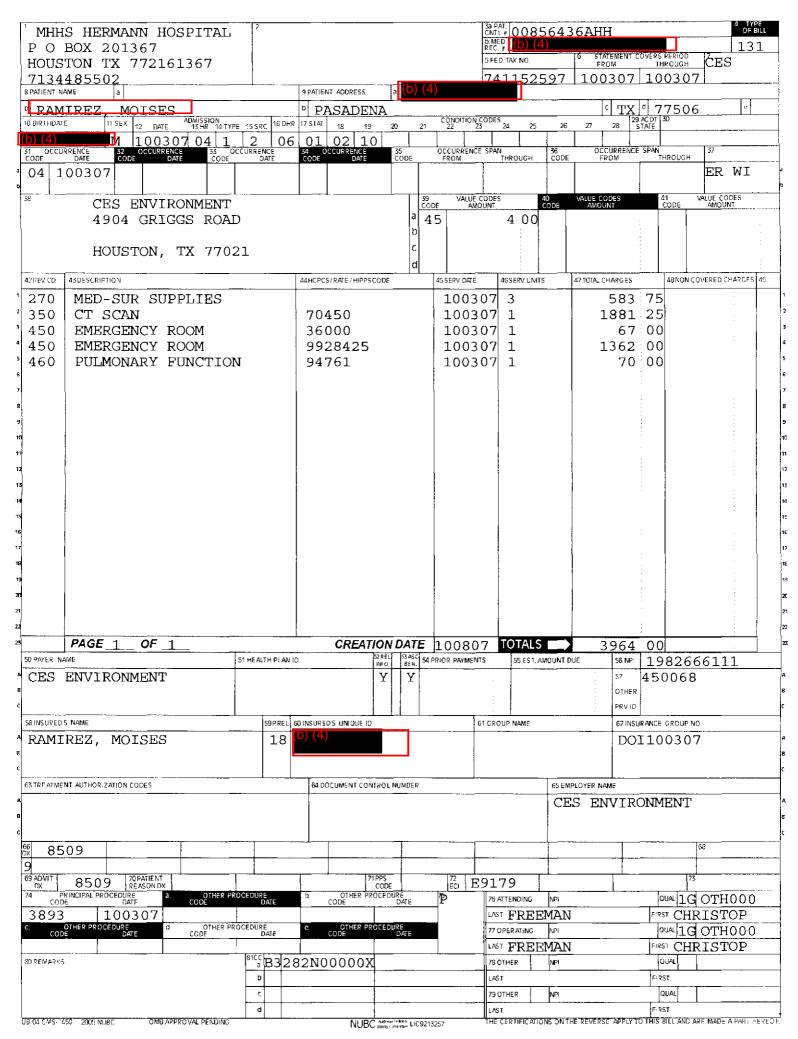
- 1. I must choose a treating doctor from the list of doctors in the network. Or, I may ask my HMO primary care physician to agree to serve as my treating doctor. If I select my HMO primary care physician as my treating doctor, I will call Texas Mutual at (800) 859-5995, extension 2880 to notify them of my choice.
- 2. I must go to my treating doctor for all health care for my injury. If I need a specialist, my treating doctor will refer me. If I need emergency care, I may go anywhere.
- 3. The insurance carrier will pay the treating doctor and other network providers.
- 4. I might have to pay the bill if I get health care from someone other than a network doctor without network approval.
- 5. Making a false or fraudulent workers' compensation claim is a crime that may result in fines and or imprisonment.

| Mongés Raminez cal descén 8-16-07 Signature Date |
|--|
| Printed Name |
| I live at: Street Address |
| City State Zip Code |
| Name of Employer: CES Envisionmental Sovices, Inc |
| Name of Network: Texas Star Network _{SM} |
| Network service areas are subject to change. Call (800) 381-8067 if you need a network treating provider. |
| Please indicate whether this is the: |
| Initial Employee Notification |
| ☐ Injury Notification (Date of Injury:/) |

DO NOT RETURN THIS FORM TO TEXAS MUTUAL INSURANCE COMPANY UNLESS REQUESTED

Employee Notice of Network Requirements - 03/06

Page 8 of 8



Memorial Hermann OUTPATIENT AHH CLAIM FOR TX 77216-1367 CLAIM DATE NAME AND ADDRESS OF INS PAGE NUMBER RAMIREZ, MOISES 10/07/07 SM01 PERIOD COVERED BY CLAIM THRU 10/03/07 10/03/07 INSURANCE COMPANY NAME RELATION TO PATIENT SOCIAL SECURITY NO 999-99-9999 WORK COMP NON-SUBSCRIBER PATIENT MAIL CLAIM TO GROUP POLICY HOLDER CES ENVIRONMENT CES ENVIRONMENT 4904 GRIGGS ROAD TX 77021 HOUSTON USA GROUP/POLICY NUMBER CERTIFICATE/SUBSCRIPTION NO. 99999999 DOI 100307 PATIENT NAME ACCOUNT NUMBER M S VST 10/03/07 RAMIREZ, MOISES DTHER INSURANCE INDICATED BY HOSPITAL RECORDS NAME OF INSURED CERTIFICATE/SUBSCRIPTION NO. GROUP POLICY NO. NONE DIAGNOSIS 850.9 CONCUSSION NOS E917.9 38.93 10/03/07 VENOUS CATHETER NEC YES 81025 FREEMAN, CHRISTOP 10/03/07 YES SERVICE DATE REF NO. DESCRIPTION AMOUNT SUMMARY OF CHARGE 583.75 0270 MED-SUR SUPPLIES 1,881.25 0350 CT SCAN 0450 EMER ROOM 1,429.00 70.00 0460 PULMONARY FUNC TOTAL CHARGES 3,964.00

Memorial Hermann OUTPATIENT AHH HEALTHCARE SYSTEM CLAIM FOR P.O. 201367, HOUSTON, TX 77216-1367 NAME AND ADDRESS OF INSUR CLAIM DATE PAGE NUMBER ŘΔMIRF*7* MOISES 10/07/07 1 PERIOD COVERED BY CLAIM 10/03/07 10/03/07 THRU RELATION TO PATIENT SOCIAL SECURITY NO INSURANCE COMPANY NAME 999-99-9999 WORK COMP NON-SUBSCRIBER PATIENT MAIL CLAIM TO GROUP POLICY HOLDER CES ENVIRONMENT CES ENVIRONMENT 4904 GRIGGS ROAD TX 77021 USA HOUSTON CERTIFICATE/SURSCRIPTION NO 99999999 DOI 100307 PATIENT NAME S M VST 10/03/07 RAMIREZ, MOISES OTHER INSURANCE INDICATED BY HOSPITAL RECORDS NAME OF INSURED GROUP POLICY NO. CERTIFICATE/SUBSCRIPTION NO NSURANCE CARRIER NONE DIAGNOSIS 850.9 CONCUSSION NOS E917.9 10/03/07 38.93 VENOUS CATHETER NEC ACCIDENT REL 10/03/07 YES 81025 FREEMAN. CHRISTOP SERVICE DATE REF NO. DESCRIPTION AMOUNT 10/03/07 55001413 CARDIAC MONITOR 246.00 55040085 226.50 10/03/07 IV START BASIC MACRO TUBING 10/03/07 55040094 BLOOD PRESSURE ADULT/PED 111,25 SUB TOTAL 0270 MED-SUR SUPPLIES 583.75 10/03/07/65700026 70450 CT HEAD OR BRAIN W/O CONTRAST 1,881.25 0350 CT SCAN SUB TOTAL 1,881.25 10/03/07 55000182 99284 EC LEVEL 4 1,362.00 10/03/07 55015530 36000 INTROD NEEDLE/INTRACATH VEIN 67.00 SUB TOTAL 0450 EMER ROOM 1.429.00 PULSE CXIMETRY MULTIPLE DETERM 10/03/07 55040001 94761 70.00 SUB TOTAL 0460 PULMONARY FUNC 70.00 TOTAL CHARGES 3,964.00

****** DATE OCT-09-2007 ***** TIME 12:51 *******

DATE/TIME = OCT-09-2007 12:50

JOURNAL No. = 044

COMM. RESULT = OK

PAGE(S) = 003

DURATION = 00:00:28

FILE No. = 450

MODE = MEMORY TRANSMISSION

DESTINATION = 15122243889

RECEIVED ID =

RESOLUTION = STD

-CES Environmental Service-

***** DP-3010 *************** - - ***** - 713 676 1676- ********

******* -IND. XMT JOURNAL- ********* DATE OCT-11-2007 ***** TIME 15:21 *******

DATE/TIME = OCT-11-2007 15:20

JOURNAL No. = 133

COMM. RESULT = OK

PAGE(S) = 006

DURATION = 00:00:50

FILE No. = 539

MODE = MEMORY TRANSMISSION

DESTINATION = 15122243889

RECEIVED ID =

RESOLUTION = STD

-CES Environmental Service-

***** DP-3010 ************** - - ***** - 713 676 1676- ********

Memorial Hermann Hospital Emergency Department 6411 Fannin Street Houston, TX 77030 (713) 704-4060

| Patient Name: Mo Date: 10/03/2007 | ises Ramirez | | | | |
|---|---|--|---------------|-----------------------|--|
| AGE: | | Wt | lbs kg | į | |
| practitioner has har | alent drug product ma d written the words "I y" on the face of the _l | Brand Necessary" (| | | |
| Sig: 1 | | en 800 mg #: 30 (thirty) needed for pain, ta | ake with food | \ \ \ \ \ | |
| Refills: 0 Signature ID# Smith, Rory DO | 156 / | 6 27-52 | 216 | | |

Memorial Hermann Hospital

Emergency Department 6411 Fannin Street Houston, TX 77030 (713) 704-4060

DISCHARGE INSTRUCTIONS FOR: FOR TODAY'S VISIT ON:

Moises Ramirez Wednesday 10/03/2007

Thank you for using Memorial Hermann Hospital for your care today. It is important for you to know that the examination, treatment and x-ray reading you have received in the Emergency Care Center today have been rendered on an emergency basis only and are not intended to be a substitute for an effort to provide complete medical care. You should contact your follow-up physician as it is important that you let him or her check you and report any new or remaining problems since it is impossible to recognize and treat all elements of an injury or illness in a single emergency care center visit.

X-RAYS and LAB TESTS:

If you had x-rays today they were read by the emergency physician. Your x-rays will also be read by a radiologist within 24 hours. If you had a culture done it will take 24 to 72 hours to get results. If there is a change in the x-ray diagnosis or a positive culture we will contact you. (Make sure we have your local phone number.)

MEDICATIONS:

If you received a prescription for medication(s) today it is important that when you fill this you let the pharmacists know all the other medications that you are on and any allergies you might have. It is also important that you notify your follow-up physician of all your medications including the prescriptions you may receive today.

Care provided by Smith, Rory DO with the diagnosis of Concussion with LOC.

Thanks again for using Memorial Hermann Hospital for your treatment today. The discharge instructions for today's visit are outlined below.

| CONCUSSION (no wake-up) Ibuprofen 800 mg 30 (thirty) 1 PO every 8 hou UT Family Practice (Clinics - UT) Follow up with your PCP | urs as needed for pain, take with food |
|--|---|
| Special Notes: | |
| Follow up with your PCP in 1 week Take meds as directed Return to the ED if you develop increased paion, | , vomiting, dizziness, or for any other concerns |
| I hereby acknowledge that I have received and unany). | derstand the above instructions and prescriptions (if |
| Moises Ramirez MRN # (b) (4) | ED Physician or Nurse |

Patient Copy

PROBLEM(S)

CONCUSSION SYNDROME

[no wake-up]

A concussion occurs when there is a blow to the head with enough force to shake up the brain. This may cause a loss of consciousness ("knocked out"). Depending on how hard you hit your head, it will take from a few hours up to a few days to get better. During this time, it is common to have symptoms of headache, nausea, vomiting or dizziness. You may also notice difficulty concentrating or problems with memory. This is normal.

Symptoms should get better as the hours and days go by. Symptoms that worsen could be a sign of a more serious injury (bruise or bleeding in the brain). Therefore, watch for the warning signs below.

HOME CARE:

- 1) During the next 24 hours someone must stay with you. This person should <u>WAKE YOU EVERY TWO HOURS</u> to check for the signs below.
- 2) If you have swelling of the face or scalp, apply an ice pack (ice cubes in a plastic bag, wrapped in a towel) for 20 minutes every one to two hours until the swelling starts to go down.
- 3) You may take Tylenol or Advil (ibuprofen) for pain, unless another pain medicine was prescribed.

<u>FOLLOW UP</u> with your physician or this facility if your current symptoms do not begin to improve over the next 24 hours.

RETURN PROMPTLY or contact your doctor if any of the following occur:

- -- Repeated vomiting
- -- Severe or worsening headache
- Severe or worsening dizziness
- -- Unusual drowsiness, or unable to awaken as usual
- -- Confusion or change in behavior or speech
- -- Unequal pupils
- Convulsion (seizure)
- Increasing scalp or face swelling
- -- Redness, warmth or pus from the swollen area



PRESCRIPTION(S)

REFERRAL(S)

You are being referred to the following physician(s)

UT Family Practice (Clinics - UT) 6410 Fannin, Ste #250 Houston, Texas 832-325-6500

WHEN TO FOLLOW-UP

| DIAGNOSIS: | ☐ Memorial Hermann ☐ Memorial Hermann The Woodlands Hospital – 281-364-2328 ☐ Memorial City Hospital – 713-242-3593 |
|--|--|
| Concussion. | ── ☐ Memorial Hermann Northwest Hospital – 713-867-4608 |
| | □ Memorial Hermann Southwest Hospital – 713-456-5527 □ Memorial Hermann Southeast Hospital – 281-929-4746 |
| Date of Service: 10-03-07 | ☐ Memorial Hermann Katy Hospital – 281-395-7466 |
| | SELECT ONLY ONE DUTY RELEASE |
| FULL DUTY RELEASE: FULL RELEASE - Released to regular duty Released to regular duty with follow-u Off the remainder of today. Return to | up appointment as indicated below* |
| LIMITED DUTY RELEASE: MODIFIED DU Released to return to work/_ | TY - RETURN TO WORK |
| ☐ Wound must remain clean, dry and co ☐ Sedentary work only ☐ Limited use of affected extremity | overed ☐ No lifting restrictions ☐ 10 lbs. maximum and occasionally lifting and/or carrying small items. |
| ☐ No use of affected extremity ☐ Cannot operate: Power Machinery Vehicle | • |
| OFF DUTY: (If one full workday of the in Off duty until re-evaluated by follow-unitial Visit | |
| WORK-RELATED PRESCRIPTIONS: Were | (,) |
| URINE DRUG TESTING: Non-DOT DOT DIMA | ALCOHOL TESTING: □ Evidential Breath Test □ Breath Scan □ Blood Alcohol |
| | tional Medicine will schedule follow-up appointment will schedule follow-up appointment. Phone: |
| Address: | |
| *Follow-up with the physician / clinic of | on: |
| Patient's Signature: | Print Physician Name EC/Occ. Med. Staff Signature) |
| Memorial Hermann Hospital System FOR YOUR WHOLE LIFE™ | (b) (4) |
| Return To Work | |

1702 10/04

Espiral Melvin Accident



Claim & Information Services P.O. Box 12029 Austin, TX 78711-2029

1-800-859-5995 (512) 224-3800 Fax (512) 224-3889

November 29, 2007

C E S ENVIRONMENTAL SERVICES I

4904 GRIGGS RD HOUSTON, TX 770213208

Re:

Claim #:

Employee:

Soc. Sec.: Employer:

C E S ENVIRONMENTAL SERVICES I

Date of Injury: 11/09/2007

DWC#:

Dear C E S ENVIRONMENTAL SERVICES I,

MELVIN ESPINAL

In accordance with the Division of Workers' Compensation Rule 120.2, we are requesting that you file the employer's first report of injury or illness (DWC-1). The first report of injury can easily be submitted using our online reporting system, available thru our website, www.texasmutual.com. Or, you may download a copy of the form from our website and file the information with us by mail, phone, fax or electronic submission. The Division's rules specify that the information be filed not later than the eighth day after: 1) the receipt of notice of an occupational disease or 2) the employee is absent from work for more than one day due to the ınjury.

A written copy must be provided to the employee along with a summary of the employee's statutory rights and responsibilities. If you use our online reporting, you can print a copy of the report to give to the employee.

Texas Mutual will file this information with the Division of Workers' Compensation.

Thank you for your prompt attention to this matter. If you have any questions, please call me at 1-800-859-5995.

Sincerely,

Latonica N Ray **EXT 2107** MEDICAL WORKERS' COMP SPEC





Claim & Information Services P.O. Box 12029

1-800-859-5995 (512) 224-3800

Fax (512) 224-3889

Austin, TX 78711-2029

November 29, 2007

C E S ENVIRONMENTAL SERVICES I

4904 GRIGGS RD HOUSTON, TX 770213208

Re: Claim #: Employee:

Soc. Sec.:

Employer: C E S ENVIRONMENTAL SERVICES I

Date of Injury: 11/09/200

DWC #:



In accordance with the Division of Workers' Compensation Rules, we are requesting that you submit the information indicated below. The DWC3 and DWC6 forms are available for printing from our website, www.texasmutual.com, under services, or from the division's website, www.tdi.state.tx.us. For your convenience, a DWC3 is now available for you to complete and submit on-line. It is located on our website, www.texasmutual.com under the Employers - Loss Run & Claims Detail Section. If you need assistance with filing the DWC3 on-line please contact me. If you do not have access to the Internet, we will be happy to send you a blank form.

| | DWC3 EMPLOYER'S WAGE STATEMENT (Rule 128.2) - Please fax or email attachment or use the on-line version (www.texasmutual.com). |
|-------------|--|
| OR | |
| | DWC3SD EMPLOYER'S WAGE STATEMENT FOR SCHOOL DISTRICTS (Rule 128.7) |
| \boxtimes | DWC6 EMPLOYER'S SUPPLEMENTAL REPORT OF INJURY OR ILLNESS (Rule 120.3) - Please fax or email attachment. The following time frames apply. |
| | Within 10 days after: |

- The end of each pay period in which the employee's earnings have changed as a result of the injury, OR
- The employee returns to work, or the employee, after returning to work experiences an additional day(s) of disability as a result of the injury.

Within 3 days after:

- The employee begins to lose time from work as a result of the injury, OR
- The employee returns to work, or the employee, after returning to work experiences an additional days(s) of disability as a result of the injury

AND

EMPLOYEE ACKNOWLEDGEMENT OF WORKERS' COMPENSATION NETWORK FORM (This form(s) shall be completed, signed and submitted). Please fax or send attachment via email as soon as possible.

Failure to provide the required information is an administrative violation and may result in the assessment of a penalty from the Division of Workers' Compensation.

Thank you for your prompt attention to this matter. If you have any questions, please call me at 1-800-859-5995.

Sincerely,

Latonica N Ray EXT 2107 MEDICAL WORKERS' COMP SPEC



| CLAIM# | —————————————————————————————————————— |
|-----------|--|
| Carrier # | |
| L | |

SUPPLEMENTAL REPORT OF INJURY

| Part I EMPLOYER INFORMATION | 1 | | | | |
|---|-------------------------------|--|---------------------|-------------------------|--|
| Employer business name | | | 2. Employer phor | ne # | |
| Employer mailing address | | | | | |
| Insurance carrier name | | | | | |
| Does the employer have return to work | (RTW) opportunities available | based on the injured worker | s current capabill | ties? yes no | |
| If so, identify contact person a | nd phone # | | | | |
| 6. Has the insurance carrier provided RTW | | | Date | no [| |
| 7. Has the employer requested RTW training8. Has the insurance carrier provided accid | - | · | □ Date | no [] | |
| Has the employer requested accident provide | • | · - | | no [| |
| | | | | | |
| Part II REASON FOR FILING THE | | | | | |
| a. The injured worker returned | | | • | el | |
| b. The injured worker is earning | - | | - | - | |
| c. The injured worker returned, | | - | esuit of the injury | : File within 5 days. | |
| d. The injured worker resigned | <u> </u> | yment. File within to days. | | | |
| Part III INJURED WORKER INFO 11. Injured worker name | RIVIATION | 12, SSN | | 13. DOI | |
| | | | | { | |
| 14. Injured worker mailing address and pho | ne # | | | | |
| 15. First day of lost time or reduced wages for this injury (mm/dd/yyyy) | | 16. First day of additional or reduced wages (mr | | | |
| Has the injured worker experienced 8 diff yes, the date of the 8th day (mm/dd/yy | | reduced wages as a result of | of the injury? | yes no | |
| 18. Date of most recent RTW | 19. Has the injured worker | resigned, been terminated o | r died? | yes no | |
| Full duty, full pay | date of resignation | date of termination | (| date of death | |
| Limited duty, full pay | 19a. Reason for resignation | /termination | | | |
| Limited duty, reduced pay | 19b. Was the injured worker | on limited duty when termin | ated? | yes no | |
| 20. Hours the injured worker was working during the pay period of 21. Weekly/hourly earnings for the pay period of | | | | | |
| to : hours per week to : \$ weekly or \$ | | | | | |
| Indicated hours are: | | Indicated wages are: | | | |
| Increase from pre-injury | | i | m pre-injury wage |) | |
| Same as pre-injury | | 1 == - | -injury wage | | |
| Decrease from pre-injury | | | | | |
| This form to be filed with: The emplo | yer's insurance carrier and t | he injured worker in the til | neframe as note | d in Part II. | |
| | | | | | |
| 22. To the best of my knowledge the inform | | • | • | | |
| Submitted by: | mployer Injured V | Vorker (If no longer working | for the employer v | where injury occurred.) | |
| | | | | | |
| Signature and Title of person completing this | Form . | Date | | | |



DWC FORM-6 (Rev. 10/05) Page 1

DIVISION OF WORKERS' COMPENSATION

DWC FORM-6 Supplemental Report of Injury

DWC requires the reporting of all Return to Work and Post-Injury Change of Earnings. An injured worker is entitled to temporary income benefits if he/she has disability (defined as the inability to work, or the inability to earn wages equivalent to pre-injury wages, as a result of the injury) and has not reached maximum medical improvement (defined as having reached 104 weeks from the eighth day of lost time or when a doctor certifies that no further recovery can be reasonably anticipated). The insurance carrier shall adjust the weekly amount of temporary income benefits paid to the injured worker to match the fluctuations in weekly earnings after the injury. To ensure the insurance carrier has accurate information to calculate benefits, the DWC FORM-6 is to be completed as applicable:

| By EMPLOYER | By INJURED WORKER | | |
|---|--|--|--|
| The EMPLOYER means the employer for whom the injured worker was working when the injury occurred. If the employer is the current employer, then you are responsible to provide information to the workers' compensation insurance carrier about: • The existence of earnings, and • The amount of any earnings, or • Any offers of employment. Include CLAIM and insurance carrier numbers in right upper hand comer. Complete items 1-21, sign and date. | If you (the INJURED WORKER) are no longer employed by the employer where the injury/illness occurred, then you are responsible to provide information to the workers' compensation insurance carrier about: • The existence of earnings, and • The amount of any earnings, or • Any offers of employment. This form may be used to do so. Include CLAIM and insurance carrier numbers in right upper hand comer. Complete items 1-4, 10-21, sign and date. | | |
| The EMPLOYER must file this form: • For a worker's injury/illness that occurs after January 1, 1991 and required the previous filing of a DWC FORM-1, Employer's First Report of Injury; and • During the time the injured worker is entitled to temporary income benefits (TIBs); and • Until the injured worker: ➤ Reaches maximum medical improvement (MMI), or ➤ Is no longer employed by the employer. | If you are employed by a new employer after the injury; and You are receiving benefits, you must tell the insurance carrier if your wages change, regardless of whether your income went up or down; or You are not receiving benefits, you must tell the insurance carrier if the injury causes you to miss work or lose income. | | |

his report must be filed in the following situations within the timeframes indicated:

- 3 days after the injured worker begins to lose time from work as a result of the injury, if lost time did not occur immediately following the injury;
- 3 days after the injured worker returns to work;
- . 3 days, when the injured worker returned to work, then later has additional day(s) of lost time as a result of the injury;
- 10 days after the end of each pay period in which the injured worker has a change in earnings as a result of the injury;
- 10 days after the injured worker resigns or is terminated.

While most of the sections on this form are self-explanatory,pl ease note that the pay periods requested in sections 20 & 21 may be different depending on the situation for which the form is being filed:

- If the report is indicating lost time from work or the end of employment, the pay period shall be the most recent pay period prior to the lost time.
- If the report is indicating return to work or a change in earnings, the pay period shall be the pay period the injured worker is beginning.

This form is to be filed by first class mail or personal delivery with:

- The insurance carrier, and
- The injured worker.

This report is considered filed when personally delivered or postmarked.

This form is to be filed by first class mail or personal delivery with:

The insurance carrier.

This report is considered filed when personally delivered or postmarked.

If you return to work for the same employer or a different employer, your temporary income benefits from the insurance carrier must be adjusted.

Failure to report earned wages and/or offers of employment to the insurance carrier who is paying benefits to you is a crime that may result in fines and/or imprisonment.

Failure to comply with these filing requirements, without good cause, is a Class D administrative violation, subject to a penalty not to exceed \$500.

TLC§ 409.005 and Rules 120.3 and 129.4 provide the requirements regarding use of this report. The complete rule text is available on the DWC website at: www.tdi.state.tx.us



DIVISION OF WORKERS' COMPENSATION

DWC FORM-6 (Rev. 10/05) Page 2

To: Dan Bowman 7136761676

Employee - You are required to report your injury to your employer within 30 days if your employer has workers' compensation insurance. You have the right to free assistance from the Texas Workers' Compensation Commission and may be entitled to certain medical and income benefits. For further information call your local Commission field office of 1(300):252-7031.



Trabajacor - Es necesario que usted reporte su lesión a su empleador dentro de 30 días a partir del día en que se lesionó, si su empleador tiene soguro de compensación para trabajactores. La Comisión Tejana de Compensación para Trabajactores le ofrece asistencia gratuita, tembién puede que usted tenga derecho a ciertos beneficios médicos y monetarios. Para mayor información litame a la oficina local de la Comisión 1-600-252-7031.

| TEXAS WORKERS' COMPENSATION WORK STATUS REPORT | | | | | |
|--|---|--|--|--|--|
| PART I: GENERAL INFORMATION | 5. Doctor's Name and Degree John M. Sanchez, MD | (for transmission Date Being Sent purposes only) | | | |
| 1. Injured Employee's Name | 6. Clinic/Facility Name | 9. Employer's Name | | | |
| Melvin Espinal | CMC - Houston I-10 East | CES Environmental | | | |
| Date of Injury 3. Social Security Number | 7. Clinic/Facility/Doctor Phone & Fax | I.O. Employer's Fax # or Email Address (if known) | | | |
| 11/09/2007 (b) (4) | | (713)676-1676 | | | |
| 4 Employee's Description of Injury/Accident | i i | 11. Insurance Carrier | | | |
| Patient states :"Patient was at work and cleaning solution get into his rt eye" | } | Texas Mutual Insurance Company | | | |
| | l | Camer's Fax # or Email Address (if known) (512)322-3889 | | | |
| PART II: WORK STATUS INFORMATIO | N (FULLY COMPLETE ONE INCLUDING ESTIMATED DATES A | ND DESCRIPTION IN 13(c) AS APPLICABLE) | | | |
| 13. The injured employee's medical condition | resulting from the workers' compensation injury: | | | | |
| (a) will allow the employee to return to v | ork as of 11/12/2007 (date) without restrictions. | | | | |
| (b) will allow the employee to return to v | ork as of (date) with the restrictions id | entified in PART III, which are | | | |
| expected to last through | (date). | | | | |
| | nployee from returning to work as of(| | | | |
| through(date). The foil | owing describes how this injury prevents the employee i | rom returning to work: | | | |
| | | | | | |
| PART III: ACTIVITY RESTRICTIONS* | REQUIRED IF BOX 13(b) IS CHECKED) | | | | |
| 14. POSTURE RESTRICTIONS (if any) : | 17. MOTION RESTRICTIONS (if any): | 19. MISC. RESTRICTIONS (If any): | | | |
| | , , , | I — ` '' ! | | | |
| Max Hours per day: 0 2 4 6 8 Othe | Max Hours per day: 0 2 4 6 8 Other | Max hours per day of work: | | | |
| Standing UUUUU | _ Walking | Sit/Stretch breaks ofper | | | |
| Sitting | Climbing stairs/ladders | Must wear splint/cast at work | | | |
| Kneeling/Squatting | Grasping/Squeezing | Must use crutches at all times | | | |
| | | | | | |
| Bending/Stooping | Wrist flexion/extension | No driving/operating heavy equipment | | | |
| Pushing/Pulling | _ Reaching | Can only drive automatic transmission | | | |
| Twisting \[\Bigcap \B | Overhead Reaching | No work/hours/day work: | | | |
| Other: | Keyboarding | in extreme hot/cold environments | | | |
| | | | | | |
| 15. RESTRICTIONS SPECIFIC TO (if application) | | at heights or on scaffolding | | | |
| L Hand/Wrist R Hand/Wrist | 18. LIFT/CARRY RESTRICTIONS (if any): | Must keep | | | |
| LArm RArm N | eck May not lift/carry objects more thanlbs | Elevated Clean & Dry | | | |
| ∏LLeg ∏RLeg ∏8 | ack for more thanhours per day | No skin contact with: | | | |
| L Foot/Ankle R Foot/Ankle | May not perform any lifting/carrying | Dressing changes necessary at work | | | |
| Other: | Other: | | | | |
| | | No running | | | |
| 16. OTHER RESTRICTIONS (if any): | | 20. MEDICATION RESTRICTIONS(if any): | | | |
| | | Must take prescription medication(s) | | | |
| | | Advised to take over-the-counter meds | | | |
| *These restrictions are based on the doctor's best und | erstanding of the employee's essential job functions. If a particular | Medication may make drowsy (possible | | | |
| | modified duty that meets these restrictions is not available, the patio | | | | |
| should be considered to be off work. Note - these res | rictions should be followed outside of work as well as at work. | Salety/ullvillg (SSDES) | | | |
| PART IV: TREATMENT/FOLLOW-UP A | PROINTMENT INFORMATION | | | | |
| | . Expected Follow-up Services Include: | | | | |
| I ⊠ | Evaluation by the treating doctor on 11/14/2007 | (date) at 12:00 am am/pm | | | |
| 372.05 Chemical conjunctivitis | Referral to/Consult withon_ | (date) atam/pm | | | |
| | Physical medicineX per week forweeks starting | | | | |
| | Special studies (list): or | (date) at am/pm | | | |
| | None. This is the last scheduled visit for this problem. At | this time, no further medical care is anticipated | | | |
| Date / Time of Visit EMPLOYEE'S SIGNATURE | 1 " 1— | of Doctor: Treating doctor | | | |
| 11/12/2007 10:32 arr Discharge Time | | Designated doctor Referral doctor | | | |
| 11/12/2007 11:39 am | , in a let | arrier-selected RME Consulting doctor WC-selected RME Other doctor | | | |
| | · · · · · · · · · · · · · · · · · · · | | | | |

DWC FORM-73 (Rev. 10/05) Page 1



DIVISION OF WORKERS' COMPENSATION

To: Prabhakar Thangudu 7136761676

Employee You are required to report your injury to your employer within 30 days if your employer has workers' compensation insurance. You have the right to free assistance from the Texas Workers' Compensation Commission and may be entitled to cerain modical and income benefits. For further information call your local Commission field office or 1(800):252-7031.



Trabajador - Es necesario que usted reporte su lesión a su empleador dentro de 30 días a panir del día en que se lesionó, si su empleador tiene seguro de compensación para trabajadores. Ta Comisión Tejana de Compensación para Trabajadores le offece asistencia gratuita, también puede que usted tenga derecho la ciertos beneficios médicos y monetarios. Para mayor información liame a la oficina local de la Comisión 1-800-252-7031.

TEXAS WORKERS' COMPENSATION WORK STATUS REPORT Date Being Sent (for transmission Doctor's Name and Decree **PART I: GENERAL INFORMATION** purposes only) John M. Sanchez, MD Injured Employee's Na Clinic/Facility Name Melvin Espinal CES Environmental CMC - Houston I-10 East 2. Date of Injury Social Security Number Clinic/Facility/Doctor Phone & Fax 10 Employer's Fax # or Email Address (if known) (713)973-7947 11/09/2007 (713)973-7943 (713)676-1676 Clinic/Facility/Doctor Address (street address) Patient states: "Patient was at work and cleaning 10909 I-10 East Frwy Texas Mutual Insurance Company solution got into his ri eye" Zip State 12. Carrier's Fax # or Email Address (if known) TX 77029 PART II: WORK STATUS INFORMATION (FULLY COMPLETE ONE INCLUDING ESTIMATED DATES AND DESCRIPTION IN 13(c) AS APPLICABLE) The injured employee's medical condition resulting from the workers' compensation injury: X (a) will allow the employee to return to work as of 11/12/2007 (date) without restrictions. will allow the employee to return to work as of ___(date) with the restrictions identified in PART III, which are expected to last through _ _(date). (c) has prevented and still prevents the employee from returning to work as of (date) and is expected to continue _(date). The following describes how this injury prevents the employee from returning to work: PART III: ACTIVITY RESTRICTIONS* (REQUIRED IF BOX 13(b) IS CHECKED) 14. POSTURE RESTRICTIONS (if any) : 17. MOTION RESTRICTIONS (if any): 19. MISC. RESTRICTIONS (if any): Max hours per day of work: 0 2 4 6 B Other Max Hours per day: Q 2 4 6 8 Other Max Hours per day: Standing Sit/Stretch breaks of Climbing stairs/ladders Sitting Must wear splint/cast at work Kneeling/Squatting Grasping/Squeezing Must use crutches at all times Wrist flexion/extension Bending/Stooping No driving/operating heavy equipment Pushing/Pulling Reaching Can only drive automatic transmission Overhead Reaching Twisting No work/ ___hours/day work: in extreme hot/cold environments Other: Keyboarding at heights or on scaffolding 15. RESTRICTIONS SPECIFIC TO (if applicable) 18. LIFT/CARRY RESTRICTIONS (if any): Must keep_ L Hand/Wrist R Hand/Wrist May not lift/carry objects more than L Arm Elevated Clean & Dry | | R Arm Neck ∏]LLeg R Leg for more than ____hours per day Back No skin contact with:_ L Foot/Ankle R Foot/Ankle May not perform any lifting/carrying Dressing changes necessary at work Other: No running 16. OTHER RESTRICTIONS (if any): 20. MEDICATION RESTRICTIONS(if any): Must take prescription medication(s) Advised to take over-the-counter meds These restrictions are based on the doctor's best understanding of the employee's essential job functions. If a particular Medication may make drowsy (possible) restriction does not apply, it should be disregarded. If modified duty that meets these restrictions is not available, the patiel safety/driving issues) should be considered to be off work. Note - these restrictions should be followed outside of work as well as at work PART IV: TREATMENT/FOLLOW-UP APPOINTMENT INFORMATION 21. Work Injury Diagnosis Information: 22. Expected Follow-up Services include: ☑ Evaluation by the treating doctor on 11/14/2007 (date) at 12:00 am am/pm 372.05 Chemical conjunctivitis Referral to/Consult with (date) at_ am/pm Physical medicine _ _X per week for ___ _weeks starting on _ (date) at_ Special studies (fist): (date) at_ None. This is the last scheduled visit for this problem. At this time, no further medical care is anticipated Date / firme of Visit DOCTOR'S SIGNATURE Treating doctor **EMPLOYEE'S SIGNATURE** Visit Type: Role of Doctor Designated doctor 11/12/2007 10:32 an Referral doctor Initial Discharge Time Carrier-selected RME Consulting doctor

DWC FORM-73 (Rev. 10/05) Page 1

11/12/2007 11:39 ar

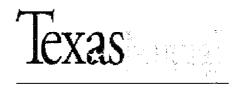


Follow-up

DIVISION OF WORKERS' COMPENSATION

DWC-selected RME

☐ Other doctor



11/14/2007

C E S ENVIRONMENTAL SERVICES I 4904 GRIGGS RD HOUSTON TX 77021-3208

Notification Confirming Receipt of Claim

Date of Injury: 11/09/2007

Injured Worker: ESPINAL, MELVIN
Claim Number: (b) (4)
Policy Number: 0001086044

Attached is a copy of the information you reported to Texas Mutual Insurance Company which was used to establish this claim. You may submit additional claim information to Texas Mutual Insurance Company. If you bave questions regarding this report of injury please contact us at (800) 859-5995.

If your policy includes our workers' compensation health care network option you are required by law to obtain a second Employee Acknowledgement of Workers' Compensation Network Form signed by the injured worker. Please submit a copy of the signed, second acknowledgement form to Texas Mutual Insurance Company. You can find a copy of the form online at www,texasmutual.com/hcn/hcn.shtm

Below please find information that will help you through the claim process:

To submit additional claim information:

Mail to: P. O. Box 12029 Austin, Texas 78711-2029

Fax to: (512) 224-3889

To locate a treating doctor:

www.texasmutual.com/workers/iwADL.shtm

To contact the handling adjuster:

Call: (800) 859-5995

Monday - Friday; 8:00 a.m. - 5:30 p.m.

To obtain a copy of the Employer and Employee Rights and Responsibilities in the Workers' Compensation System:

www.texasmutual.com/employers/erRights.shtm

To locate a pharmacy, or for pharmacy questions, contact Scripnet:

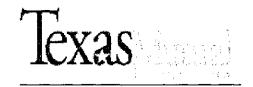
Call: (888) 880-8562 www.scripnet.com

To obtain a copy of the Employer and Employee Rights and Responsibilities for the

workers' comp health care network: www.texasmutual.com/hcn/hcn.shtm

Additional Texas Mutual® online services at www.texasmutual.com, available 6 a.m. - 9 p.m., include:

- o Obtain logon id, or for immediate logon id, call (800) 859-5995, M-F, 8:00 a.m. 5:30 p.m.
- o Submit first report of injury in the Employers section
- o Submit wage statement when reviewing loss runs and claim details
- o Obtain specific claim summary information



Claim Number:

99H0000510898

Notification Date: 11/12/2007

EMPLOYER'S FIRST REPORT OF INJURY

Address:

INJURED EMPLOYEE

Name: SSN:

MELVIN ESPINAL XXX-XX(b)

Mailing

Address:

County:

Physical Address:

County:

Home Phone:

Date of Birth: 00/00/0000 Marital Status: Unknown

Gender:

Male

Dependents: ()()

Language:

English

MEDICAL PROVIDER

ATTORNEY

Name: JOHN M. SANCHEZ M.D.

Tax ID:

Address: 10909 I-10 EAST FRWY

HOUSTON TX 77029

Phone:

(713)973-7943

Ext:

Fax:(713)973-7947

Represented by Attorney:

Name:

Phone:

Fatality:

INJURY INFORMATION

Date of Injury: 11/09/2007 **Time:** 00:00

Date Reported: 00/00/0000 Nature of Injury: FOREIGN BODY

Cause of Injury: MISC, CAUSES-FOREIGN

MATTER(BODY) IN EYE(S)

Part of Body:

EYE(S)

No

Name:

County: Witnesses:

Name:

Phone:

Phone:

Name:

Phone:

How and Why the Injury/Illness Occurred

FOREIGN BODY RIGHT EYE - CLAIM ESTABLISHED FROM A DWC73 REPORT FROM DR. SANCHEZ EE RELEASED TO RTW WITHOUT RESTRICTIONS 11/12/07

4904 GRIGGS RD HOUSTON TX 77021-3208

BUSINESS/EMPLOYER

Phone: (713)676-1460 Ext:

Name: C E S ENVIRONMENTAL SERVICES I

Fax: (713)676-1676

Policy Number: 0001086044 FEIN:

Location ID:

EMPLOYMENT

Occupation:

Hire Date: 00/00/0000

State:

760592985

Partner/Officer/Owner: Date Lost Time Began: 00/00/0000 11/12/2007

Return to Work Date: Last Paycheck was:

Wage: Frequency:

Hours/Week: Davs/Week:

Period Start: 00/00/0000

Period End: 00/00/0000

Supervisor Name:

Phone:

Ext:

Address Where Injury Occurred:

PREPARER OF REPORT

Name:

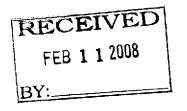
Phone: Email:

Ext:

Fax:

Robert HiCKMANI ACCIDENT 12-13-07

Mote: Sez Karl Guicky For CAMERA



AIG Domestic Claims, Inc. Property/Casualty Division

P.O. Box 25588 Shawnee Mission, KS 66225

(800) 242-2987 (all other) Fax (866) 723-0109 (new losses) Fax (866) 854-4926

AUTOMOBILE LIABILITY REOPEN ACKNOWLEDGEMENT

February 7, 2008

CES ENVIRONMENTAL SERVICES INC

4904 GRIGGS ROAD HOUSTON, TX 77021-0000 Attn: KARL GUIDRY

"onfacted Elizabeth Walter-in formed Claim is closed + Shall Remain closep. LAG 2-12-08

RE:

Insured

: CES ENVIRONMENTAL SERVICES INC

Carrier

: Commerce & Industry

Date of Loss

: 12/13/2007

Date Reported

:01/18/2008

Claim Number

: 684-215924

Date Received

:01/18/2008

This letter is to advise that the above referenced claim has been reopened for further handling.

ADDITIONAL CLAIM INFORMATION:

Policy Number

: 005062132

Loss Location

: CLINTON DR & 610 FEEDER GALENA PARK, TX

Description of Loss

: IV MAKING LEFT TURN / OV SIDESWIPED IV TRAILER / OV TRIED TO

SQUEEZE BY TURNING IN THE OTHER LANE

Insured Driver

: HICKMAN ROBERT

RISK ANALYSIS INFORMATION:

| DIVISION: | | | |
|-------------|--|---------|--|
| LOCATION: | | • | |
| DEPARTMENT: | | | and the second s |
| SECTION: | | | |
| LEVEL 5: | | <u></u> | |
| LEVEL 6: | | , s.m | |

CLAIMANT INFORMATION:

Symbol Name

MJC

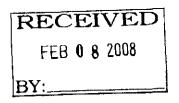
001 **EUGENE JOHNSON** 007

002 CES ENVIRONMENTAL SERVICES, IN

009

If you have any comments or questions, please feel free to contact me. Kindly refer to the above claim number on any correspondence.

Sincerely, **ELIZABETH WALTER** FAST TRACK REP 251-PC OVERLAND PARK, KS (913) 338-9298 ELIZABETH.WALTER@AIG.COM Original



AIG Domestic Claims, Inc. Property/Casualty Division

P.O. Box 25588 Shawnee Mission, KS 66225 (800) 242-2987 (all other) Fax (866) 723-0109 (new losses) Fax (866) 854-4926

AUTOMOBILE LIABILITY CLOSED CLAIM NOTICE

February 4, 2008

CES ENVIRONMENTAL SERVICES INC 4904 GRIGGS ROAD HOUSTON, TX 77021-0000

Attn: KARL GUIDRY

RE:

Insured

: CES ENVIRONMENTAL SERVICES INC

Carrier

: Commerce & Industry

Date of Loss Claim Number 12/13/2007

Date Reported

: 01/18/2008

Date Received

: 01/18/2008

The above captioned claim has been closed. The following amounts were paid on the claim:

Symbol Claimant

MJC

Medical

Legal

001

EUGENE JOHNSON

007

Indemnity \$2,053,97

002

CES ENVIRONMENTAL SERVICES, IN

009

\$85.52

ADDITIONAL CLAIM INFORMATION:

Policy Number

: 005062132

Loss Location

: CLINTON DR & 610 FEEDER GALENA PARK,TX

Description of Loss

: IV MAKING LEFT TURN / OV SIDESWIPED IV TRAILER / OV TRIED TO

SQUEEZE BY TURNING IN THE OTHER LANE

Insured Driver

: HICKMAN ROBERT

RISK ANALYSIS INFORMATION:

| DIVISION: | | | |
|-------------|------|------|--|
| LOCATION: | | | |
| DEPARTMENT: | | | |
| SECTION: | | | |
| LEVEL 5: | | | |
| LEVEL 6: | | | |

Thank you for allowing us to serve you on this claim. Please contact me if you have any questions or comments.

Sincerely, **ELIZABETH WALTER** FAST TRACK REP 251-PC OVERLAND PARK, KS (913) 338-9298 ELIZABETH.WALTER@AIG.COM Original

AIG Domestic Claims, Inc. Property/Casualty Division

P.O. Box 25588 Shawnee Mission, KS 66225 (800) 242-2987 (all other) Fax (866) 723-0109 (new losses) Fax (866) 854-4926

AUTOMOBILE LIABILITY NEW CLAIM ACKNOWLEDGEMENT

January 24, 2008

CES ENVIRONMENTAL SERVICES INC

4904 GRIGGS ROAD

HOUSTON, TX 77021-0000 Attn: KARL GUIDRY

RE:

Insured

: CES ENVIRONMENTAL SERVICES INC

Carrier

: Commerce & Industry

Date of Loss Claim Number 12/13/2007 (b) (4) Date Reported

: 01/18/2008

Date Received

: 01/18/2008

This letter will confirm receipt of the above referenced claim.

ADDITIONAL CLAIM INFORMATION:

Policy Number

005062132

Loss Location

: CLINTON DR & 610 FEEDER GALENA PARK,TX

Description of Loss

: IV MAKING LEFT TURN / OV SIDESWIPED IV TRAILER / OV TRIED TO

SQUEEZE BY TURNING IN THE OTHER LANE

Insured Driver

: HICKMAN ROBERT

RISK ANALYSIS INFORMATION:

| THOUSE THE TENED TO THE TO | 241-22 - 2 2 2 0 1 11 | | |
|----------------------------|-----------------------|------|--|
| DIVISION: | | | |
| LOCATION: | | | |
| DEPARTMENT: | | | |
| SECTION: | | | |
| LEVEL 5: | | | |
| LEVEL 6: | | | |

CLAIMANT INFORMATION:

 Symbol
 Name
 MJC

 001
 EUGENE JOHNSON
 007

 002
 CES ENVIRONMENTAL SERVICES, IN
 009

If you have any comments or questions, please feel free to contact me. Kindly refer to the above claim number on any correspondence.

Sincerely, ELIZABETH WALTER FAST TRACK REP 251-PC OVERLAND PARK, KS (913) 338-9298 ELIZABETH.WALTER@AIG.COM Original

Karl Guidry

From: Karl Guidry

Sent: Friday, January 18, 2008 9:25 AM

To: 'bperez@ins-alliance.com'

Subject: FW: accident

Good morning Belinda,

Below is the message I received regarding Laura Toliver.

Karl

From: Elaine Williams [mailto:

Sent: Friday, December 14, 2007 4:26 PM

To: Karl Guidry Subject: accident

Time of accident Approx.6 A.m. on Dec 13,2007

As I Laura Toliver approached the red light of the 9100 block of Clinton Dr. I was in the left lane a eighteen wheeler was next to me in the right lane, as the light turned green I was making a left turn, as was the truck. the truck driver not paying attentionand on his cell phone did not turn wide enough causing a collision with my automobile, causing damage to the right door and the window also damaging my rightside rearview mirror. He proceeded to drive off and as he did I blew my horn at him, he did not stop until he reached Clinton and Stewart 2 and a half miles from the accident. He seemed unconcerned and still on his cell phone. He also failed to ask me if I was ok, didn't speak to me or provided me with the nescery information that I needed in order to repair my vehicle. After the police showed up the police provided me with a number to call, the policwe confronted the driver, as the police left, the truck driver provided me with the information.



Looking for last minute shopping deals? Find them fast with Yahoo! Search.



4904 Griggs Road Houston, TX 77021 Phone: (713) 676-1460

Fax: (713) 676-1676



то: Insurance Alliance From: Karl Guidry

Mobile: (832) 287-0862

Fax: 713-966-1700 Pages: 2 Pages to follow

Attn: Belinda Perez Date: January 18, 2008

Ms. Perez,

Documents we discussed.

Karl Guidry

ACCIDENT DESCRIPTION

| Explain in your own v unite maki Clinton dr ently side trying to in two of | words what happened. My a left turn onto Ariver of car apper- e swipted Trailer squeze by turning her lane. |
|---|--|
| | |
| Draw a diagram of ac | ccident using 1 as |
| your vehicle, | as vehicle No. 2, etc. |
| e. | |
| | cliaton dr. |
| • | |
| | Z. |
| W | ITNESSES |
| Name | Address |
| Phone | Workplace |
| | Address |
| Phone | Workplace |

DRIVER'S REPORT AT ACCIDENT SCENE

| Checklist | | | |
|---|--|--|--|
| Stop and Investigate | | | |
| Set Warning Devices | | | |
| Help the Injured | | | |
| Protect Your Vehicle and Cargo from Theft and Further Damage | | | |
| ☐ Do Not Move Your Vehicle Until Police Arrive | | | |
| Contact Supervisor as Soon as Possible. (Use accident notification card if you can't leave) | | | |
| Discuss Accident Only with Proper Authorities | | | |
| Obtain Names and Addresses of Witnesses. (Use witness cards supplied) | | | |
| ☐ Complete This Card At the Scene of Accident | | | |
| ☐ Comply With Any Required Alcohol/Drug Test | | | |
| RETURN ENTIRE PACKET TO SUPERVISOR | | | |
| © Copyright 1995 & Published By: | | | |

| DRIVER Robert Hickman | YOUR VEHICLE |
|---|---|
| ACCIDENT DATA | Were any mechanical defects apparent at the time of |
| | the accident? 10 Explain Explain |
| Date 12-13-07 Time 6600 □ P.M. | VIN (b) (4) |
| Place Galera Pork TV | 4114 |
| (Town, City, State) | Were you wearing safety belts? 4eડ |
| Roadway Clinton dr. + I-610 Feeder (Rt. #, Street, Intersecting Hwys) | |
| Landmark | VEHICLE NO. 2 |
| (Near bridge, milepost, etc.) | Type Car Make Buike |
| DEATH AND INJURY | Model Riveard Year 94 |
| | Driver Laura Jean Toliver |
| Persons Killed Not | Address (0) (4) |
| Paragraph of A | (b) (4) |
| Persons Injured | License # & State 9313 wississippi |
| Was anyone taken away from scene for medical | Owner Address Galaxy (As. 713-643-28 |
| treatment (Who & Where Taken) | 7.001000 - 1 |
| | (b) (4) Old American |
| | Phone Insurance Co. County mutue |
| INVESTIGATION | EHICLE NO. 3 |
| Was Accident Investigated by Police? 125 | Type Make |
| Department Galeria Park Badge # | Model Year |
| Officer | Driver |
| Citation Issued? No | Address |
| List persons cited or arrested & charges | |
| | License # & State |
| | Owner |
| | Address |
| | Phone Insurance Co. |

POST ACCIDENT TESTING DETERMINATION

| Driver's Name: | ID: | Facility: | | |
|----------------------------------|---|-------------------------|-------------------------|---|
| Date of Accident: | Time of Accident: | Location: | | |
| Time Driver Instructed to b | e Tested: | Time Driver wa | s Tested: | |
| Does vehicle meet the defin | nition of a commercial motor vehicle | ? J YES | □ NO | |
| If no, do NOT conduct a | DOT Drug or Alcohol Test. | | | |
| If yes, check the type of | commercial motor vehicle. | | | |
| | ination weight rating of 26,001 or more pong of more than 10,000 pounds; or | unds inclusive of a tow | ed unit with a | |
| ☐ Vehicle has a gross vehic | le weight rating of 26,001 or more pounds; | , ог | | |
| ☐ Vehicle is designed to tra | nsport 16 or more passengers, including the | e driver; or | | |
| ☐ Vehicle is of any size and | is used in the transportation of hazardous | materials requiring pla | cards. | |
| If d | river was operating a CMV, did a If yes, then a DOT Drug and | | | |
| (IF NO) | ^ | | | |
| | / \ | | | |
| ** Did the driver | INJUR Did anyone r | | | |
| receive a | YES immediate m | nedical | YES | * DOT Drug & Alcohol Test Required |
| citation? | the scene o | f the | | |
| \perp | accident | | | |
| NO | | | | |
| Do NOT conduct a | | | | |
| DOT Drug or Alcohol Test. | | | | |
| | , name | OTE C | | |
| | DAMAG Did any vehic | | YES | * DOT Drug & Alcohol Test Required |
| | disabling dan | nages? | | |
| | | | 1 | NOTES |
| | Y | | * Test must be conduc | cted immediately alcohol |
| | NO | | | rug test within 32 hours. est is not authorized if the |
| | Do NOT con | | driver does not receiv | e a citation within 8 hours. |
| | DOT Drug Alcohol T | | does not receive a cita | is not authorized if the driver ation within 32 hours. |
| | | | | |
| | | | | |
| ☐ It was determined that a DO | Γ Drug & Alcohol Test was not necessary f | or the following reason | as: | |
| ☐ It was determined that a DO | Γ Drug & Alcohol Test was necessary for the | ū | | |
| If an alcohol test was not compl | eted within 2 hours, provide reason: | | | |
| If a drug test was not completed | l within 32 hours, provide reason: | | | |
| | | | Date: | |
| Name | NC Noopoh WI + 1-900-327 6969 a namu iikollor com a Printed ir | Title | | 533 - F 9372 |

ATTENTION: DRIVER'S INVOLVED IN A MOTOR VEHICLE ACCIDENT

Review this Part of the Department of Transportation regulations for compliance with alcohol and controlled substance testing post-accident requirements.

§382.303 Post-accident testing.

- (a) As soon as practicable following an occurrence involving a commercial motor vehicle operating on a public road in commerce, each employer shall test for alcohol for each of its surviving drivers:
- (1) Who was performing safety-sensitive functions with respect to the vehicle, if the accident involved the loss of human life; or
- (2) Who receives a citation within 8 hours of the occurrence under State or local law for a moving traffic violation arising from the accident, if the accident involved:
- (i) Bodily injury to any person who, as a result of the injury, immediately receives medical treatment away from the scene of the accident; or
- (ii) One or more motor vehicles incurring disabling damage as a result of the accident, requiring the motor vehicle to be transported away from the scene by a tow truck or other motor vehicle.
- (b) As soon as practicable following an occurrence involving a commercial motor vehicle operating on a public road in commerce, each employer shall test for controlled substances for each of its surviving drivers:
- (1) Who was performing safety-sensitive functions with respect to the vehicle, if the accident involved the loss of human life; or
- (2) Who receives a citation within thirty-two hours of the occurrence under State or local law for a moving traffic violation arising from the accident, if the accident involved:
- (i) Bodily injury to any person who, as a result of the injury, immediately receives medical treatment away from the scene of the accident; or
- (ii) One or more motor vehicles incurring disabling damage as a result of the accident, requiring the motor vehicle to be transported away from the scene by a tow truck or other motor vehicle
- (c) The following table notes when a post-accident test is required to be conducted by paragraphs (a)(1), (a)(2), (b)(1), and (b)(2) of this section:

| TABLE FOR §382.303 (A) AND (B) | | |
|--|---|------------------------------------|
| Type of accident involved | Citation is- sued to the CMV driver | Test must be performed by employer |
| i. Human fatality | YES | YES |
| | NO | YES |
| ii. Bodily injury with immediate medical treatment away from the secue | YES | YES |
| treatment away from the secue | NO | NO |

| TABLE FOR §382.303 (A) AND (B) | | |
|--|-----|-----|
| Type of accident involved Citation issued to the CMV driver CMV driver Citation issued to the performe employer | | |
| iii. Disabling damage to any motor vehicle requiring tow away | YES | YES |
| | NO | NO |

- (d)(1) **Alcohol tests.** If a test required by this section is not administered within two hours following the accident, the employer shall prepare and maintain on file a record stating the reasons the test was not promptly administered. If a test required by this section is not administered within eight hours following the accident, the employer shall cease attempts to administer an alcohol test and shall prepare and maintain the same record. Records shall be submitted to the FMCSA upon request.
- (2) Controlled substance tests. If a test required by this section is not administered within 32 hours following the accident, the employer shall cease attempts to administer a controlled substances test, and prepare and maintain on file a record stating the reasons the test was not promptly administered. Records shall be submitted to the FMCSA upon request.
- (e) A driver who is subject to post-accident testing shall remain readily available for such testing or may be deemed by the employer to have refused to submit to testing. Nothing in this section shall be construed to require the delay of necessary medical attention for injured people following an accident or to prohibit a driver from leaving the scene of an accident for the period necessary to obtain assistance in responding to the accident, or to obtain necessary emergency medical care.
- (f) An employer shall provide drivers with necessary postaccident information, procedures and instructions, prior to the driver operating a commercial motor vehicle, so that drivers will be able to comply with the requirements of this section.
- (g)(1) The results of a breath or blood test for the use of alcohol, conducted by Federal, State, or local officials having independent authority for the test, shall be considered to meet the requirements of this section, provided such tests conform to the applicable Federal, State or local alcohol testing requirements, and that the results of the tests are obtained by the employer.
- (2) The results of a urine test for the use of controlled substances, conducted by Federal, State, or local officials having independent authority for the test, shall be considered to meet the requirements of this section, provided such tests conform to the applicable Federal, State or local controlled substances testing requirements, and that the results of the tests are obtained by the employer.
 - (h) **Exception.** This section does not apply to:
- (1) An occurrence involving only boarding or alighting from a stationary motor vehicle; or
- (2) An occurrence involving only the loading or unloading of cargo; or
- (3) An occurrence in the course of the operation of a passenger car or a multipurpose passenger vehicle (as defined in §571.3 of this title) by an employer unless the motor vehicle is transporting passengers for hire or hazardous materials of a type and quantity that require the motor vehicle to be marked or placarded in accordance with §177.823 of this title.

DRIVER'S REPORT AT ACCIDENT SCENE

| Checklist |
|---|
| Stop and Investigate |
| Set Warning Devices |
| Help the injured |
| Protect Your Vehicle and Cargo from Theft and Further Damage |
| Do Not Move Your Vehicle Until Police Arrive |
| Contact Supervisor as Soon as Possible. (Use accident notification card if you can't leave) |
| Discuss Accident Only with Proper Authorities |
| Obtain Names and Addresses of Witnesses. (Use witness cards supplied) |
| Complete This Card At the Scene of Accident |
| Comply With Any Required Alcohol/Drug Test |
| RETURN ENTIRE PACKET TO SUPERVISOR |
| © Copyright 1995 & Published By: J. J. KELLER & ASSOCIATES, INC Neenah, WI 54957-0368 33F-2 Rev. 12/99 FM 5815 |

| DRIVER Robert Hickman | YOUR VEHICLE |
|--|--|
| ACCIDENT DATA | Were any mechanical defects apparent at the time of the accident? Δυ Explain |
| Date 12-13-07 Time 6600 P.M. | VIN (b) (4) |
| Place Galera Park TX. (Town, City, State) | ——- Were you wearing safety belts? ყლე |
| Roadway Clinton dr. + I-610 Feeder (Rt. #, Street, Intersecting Hwys) Landmark | VEHICLE NO. 2 |
| (Near bridge, milepost, etc.) | Type car Make Buike |
| DEATH AND INJURY | Model Riveara Year 94 |
| Persons Killed Not | Address (b) (4) |
| Persons Injured | License # & State 93 3 Wississippi |
| Was anyone taken away from scene for medical treatment (Who & Where Taken) | Owner Address Galaxy Ins. 713-643-28 Uniter Automobil Ins. Ca1-666-22 Phone (b) (4) Insurance Co. County Mutual |
| INVESTIGATION | EHICLE NO. 3 |
| Was Accident Investigated by Police? ۲۷۵ | Type Make |
| Department Galeria Park Badge # | Model Year |
| Officer | Driver |
| Citation Issued? | Address |
| List persons cited or arrested & charges | |
| | License # & State |
| | Owner |
| | Address |
| | Phone Insurance Co. |

ACCIDENT DESCRIPTION

| Explain in your own vertile making drawing to in the off | words what happened. was a left turn onto adriver of car apper- e swipted Trailer squeze by turning her lake. |
|--|--|
| Draw a diagram of ac | ccident using 1 as 2 as vehicle No. 2, etc. |
| - | ciinton dri |
| | K. |
| W | ITNESSES |
| Name | Address |
| | Workplace |
| | |

OSHA 5-10-2008



HOUSTON SOUTH AREA OFFICE

| Carl COMPANY: CES Environ wenter FAX NUNCBER: 713-676-1676 | PATE: MAY | 1 | DFFIC | |
|--|---------------|---------------|---------|------------------|
| CES Environmental FAX NUNBER: 713-676-1676 | MAY | 1 | 200 | |
| 713-676- 1676 | TOTAL NO. OF | | | |
| PHONE NUMBER: | 5 | PAGES IN • | CLUDING | COVER: |
| | SENDER'S REFE | RENCE N | UNBER: | |
| Complaint 206298 | YOUR REFEREN | ICE NUM | BER: | |
| . URGENT FOR REVIEW PLEASE COMM | IGNT PL | .ease r | EPLY | ☐ PLGASE RECYCLE |

17625 EL CAMINO REAL, SYE. 400 HOUSTON, TX 77058 281-286-0583, FAX: 281-286-4352

U.S. Department of Labor

Occupational Safety and Health Administration Houston South Area Office 17625 El Camino Real, Suite 400 Houston, TX 77058 (281) 286-0583 FAX: (281) 286-6352



May 7, 2008

CES Environmental Services Inc. 4904 Griggs Road Houston, TX 77021

Re: CES Environmental Services Inc. Complaint No. 206298507

Dear Sirs:

On 03/06/2008, the Occupational Safety and Health Administration (OSHA) received a notice of (safety and/or health) hazards at your worksite at:

4904 Griggs Road Houston, TX 77021

We notified you, by telephone, of these alleged hazards on May 7, 2008.

The specific nature of the alleged hazards is as follows:

- 1. Safety equipment is not provided to employees to use when picking up hazardous waste. 29 CFR 1910.132
- Employees/Drivers are not informed of the chemicals/hazardous wastes they are picking up and therefore exposed to an unknown chemical. 29 CFR 1910.1200 and 29 CFR 1910.120
- 3. There is no Personal Protective Equipment hazard assessment conducted to determine the correct type of safety equipment to wear. 29 CFR 1910.132

We have not determined whether the hazards, as alleged, exist at your workplace; and we do not intend to conduct an inspection at this time. However, since allegations of violations and/or hazards have been made, we request that you immediately investigate the alleged conditions and make any necessary corrections or modifications. Please advise me in writing or by fax, no later than May 15, 2008 of the results of your investigation. You must provide supporting documentation of your findings, including any applicable measurements or monitoring results, and photographs/video which you believe would be helpful, as well as a description of any corrective action you have taken or are in the process of taking, including of the corrected condition.

This letter is not a citation or a notification of proposed penalty which, according to the OSH Act, may be issued only after an inspection or investigation of the workplace. It is our goal to

assure that hazards are promptly identified and eliminated. Please take immediate corrective action where needed. We encourage employee participation in investigating and responding to any alleged hazard. If we do not receive a response from you by May 15, 2008 indicating that appropriate action has been taken or that no hazard exists and why, an OSHA inspection will be conducted. An inspection may include a review of the following: injury and illness records, hazard communication, personal protective equipment, emergency action or response, bloodborne pathogens, confined space entry, lockout and related safety and health issues.

Please note, however, that OSHA selects for inspection some cases where we have received letters in which employees have indicated satisfactory corrective action. This is to ensure that employers have actually taken the action stated in their letters.

The State of Texas offers OSHA consultation services, without charge, to assist in resolving all occupational safety and health issues.

The variety of services available or the scheduling of those services may be limited by the consultation project's requirement to give priority to small businesses in high hazard industries and by its backlog. However, you may be able to obtain similar services from your insurance carrier or private consultant in a more timely fashion. To discuss or request the services, call or write your consultation project at the following address:

Texas Worker's Compensation Commission Workers' Health and Safety Division 4000 S IH 35 Austin, Texas 78704-7491 (512) 453-8230

or

Call 1-800-RELAY TX, then ask agent to call the number you wish to reach:

Beaumont, Texas (409) 838-8400 Galveston, Texas (409) 744-5773 Houston, Texas (713) 880-0206 Ext. 4015

You are requested to post a copy of this letter where it will be readily accessible for review by all of your employees and return a copy of the signed Certificate of Posting (Attachment A) to this office along with your response. Also, you are requested to provide a copy of this letter and your response to it to a representative of any recognized employee union of safety committee if these are at your facility. Failure to do this may result in an on-site inspection. The complainant has been furnished a copy of this letter and will be advised of your response. Section 11(c) of the OSH Act provides protection for employees against discrimination because of their involvement in protected safety and health related activity.

If you have any questions concerning this matter, please contact the Area Office at the address in the letterhead. Your personal support and interest in the safety and health of your employees is appreciated.

Sincerely,

Mark R. Briggs

OSHA'S Mission: To assure safe and healthful working conditions for working men and women.

HSAO'S VISION: Utilizing the talents and skills of OSHA's finest, we will execute "The Missions" professionally, effectively, effectively, efficiency and with resect toward one another and our constituents. To meet this vision we will use the values set forth in TEAM CORE.





June 12, 2008

To: Occupational Safety & Health Administration

Houston South Area Office 17625 El Camino Real, Suite 400

Houston, Texas 77058

Attn: Armando Rodriguez

From: Karl A. Guidry

CES Environmental Services, Inc.

4904 Griggs Rd. Houston, Texas 77021

Re: Mr. Gregory Lawrence v. CES Environmental Services Case # 6-3285-08-015

Dear Sir.

This correspondence is submitted in response to the above referenced complaint dated by your office on June 6, 2008 and received by CES Environmental Services, Inc.

On June 10, 2008, regarding alleged safety and/or health hazards at our worksite. Specifically the allegations are:

- 1. Mr. Lawrence alleges he is being retaliated against for telling his supervisor on May 11, 2008 that the tank cars that are being cleaned on the inside should be considered a permit required confined space, with all the necessary precautions in place. Response: CES HSE Manager Karl A. Guidry was informed by Mr. Lawrence on May 11, 2008 regarding his confined space concerns relative to work being performed in the Tankwash area. Mr. Guidry immediately accompanied Mr. Lawrence to the Tankwash area, viewed the tank cleaning in progress, spoke with the Tank wash Foreman and informed Mr. Lawrence his concerns would be addressed. Mr. Guidry reviewed the OSHA Standard 29 CFR 1910.146 Confined Spaces and the facility Confined Space Safety Policy. At ~ 8:00 pm on May 11, 2008 Mr. Guidry encountered Mr. Lawrence and informed him of the action steps taken which include:
 - Mr. Guidry concluded the vessel cited by Mr. Lawrence was considered a
 non-permit required confined space based on several means of egress,
 adequate ventilation which caused the atmospheric conditions to read at
 20.9% oxygen on our atmospheric monitor and the fact the facility policy
 requiring cleaning of any vessel prior to any entry removed any potential
 hazards.
 - Mr. Guidry revised the facility Confined Space safety policy to clarify the
 methodology to be used in determining the difference between a permit
 required and non-permit required confined space and the necessary actions
 to follow prior to entry of either vessel.

- On May 12, 2008 Mr. Guidry requested Mr. Lawrence to review the language in the revised facility confined space policy and Mr. Lawrence stated he was satisfied with the clarification.
- On May 12, 2008 Mr. Guidry also informed Mr. Lawrence of the facility intent to hire a person to perform attendant duties for all vessels to be entered in the Tankwash area. Mr. Lawrence communicated he was satisfied with our response.
- The changes to the facility confined space safety policy and the hiring of an attendant was completed in a matter of days and was in effect at the time your office received this complaint from Mr. Lawrence. A copy of the facility Confined Space Standard Operating Procedure is attached for your review.
- Mr. Lawrence was commended for bringing his safety concern to our attention and was encouraged to continue to do so in the future.
- 2. The company is aware that a complaint was initiated by the Houston South Area Office handled by phone/fax on May 7, 2008 and suspects he is the complainant.

Response: The company is aware a complaint was faxed on May 7, 2008 and Mr. Lawrence was "asked" if he was the person who filed the complaint. Mr. Lawrence stated he was not the person who filed the complaint. Mr. Lawrence was then requested to notify CES management in the event he ever believed there were issues he and CES needed to be concerned about. It should be noted Mr. Lawrence was not the only employee questioned about the complaint of May 7, 2008 or encouraged to bring matters of concern to the attention of facility management..

3. The retaliation began on May 13, 2008 and continues to this date.

Response: CES Environmental Services, Inc. denies retaliation occurred or is occurring. Such a position is supported by the fact Mr. Lawrence received a favorable performance review on June 1, 2008 and was awarded an annual pay increase of \$3,146 based on an average 53 hour work week. The pay 6.25% pay increase becomes effective on June 20, 2008, which is his one year employment anniversary date. A copy of the performance review is attached for your review.

If you require any additional information, please do not hesitate to let us know. We hope this response clarifies the issues under investigation and your office will see fit to bring this matter to a close.

Regards

Karl A. Guidry HSE Manager

713-676-1460 Ext 115

832-287-0862 Cell

kguidry@cesenvironmental.com

CES Environmental Services Version 7-Sep-07 Employee Evaluation Employee Division Pay grade Current Rate Midpoint Trans D3 78.0% Supervisor Maria State Type of Evaluation Date Semi-Annual Random Annual Quarterly Monthly Bonus % **Points** Generic Standards Rating Failing 0 Below 60 Failing. Automatic 30 Day probation or termination. Sub-Par 0 60 or above Fails to perform one or more key functions to standard. Performs all key functions to standard. May excel in some or be substandard in some 70 or above 80% non-key areas. Average Performs all key functions to standard or better. Does things without being told. 100% Learns new skills and generally works hard most of the time. Above Average 80 or above Excels in all key functions. Aggressively learns and looks for additional responsibility. LEADS by example and strives to build company culture. Team player who puts success of CES first. Trustworthy in all things. Not afraid to fail but Excellent 110% 90 or above rarely - if ever - makes the same mistake twice. Timely. "Fire Once and forget". Criteria Rating (1-10) Weight Score Adheres to Company SOPs 15% 13.5 Follows Employee Mandates 13.5 Quality of Leadership 10% Safe and Responsible. Appropriate use of CES assets. 10% 9 5% Demonstrates respect and honor for all people 4 Takes responsibility for actions or lack of action 5% 4.5 Demonstrates balance to commitments to work and home 10% Does the right thing regardless of what the crowd does 10% Embraces challenges. Not daunted by setbacks - refuses to fail 4.5 Quality and Quantity of work Job Specific I Works hard and gets job done in timely manner 5% 4.5 Housekeeping Job Specific 1 4.5 Job Specific 1 Communication 5% 4.5 Managers Overall Rating 100% 88 New Hrly Rate 17.01 Mgr Discretion Net 17.01 Notes

Greg is relentless in the pursuit of getting his point across, to the extent of confrontation. Working on this would be to advantage because of strong personality.

Greg always gets his work done in a timely fashion, yet when asked to do extra work he feels like the focus is on him.

EPAHO043000153

Standard Operating Procedure

| THINK USE GOOD JUDGMENT | CES Environmental Services, Inc. | YOUR ATTITUDE COUNTS |
|-------------------------------|---|---|
| Date Issued | DEPARTMENT (S) - Operations - Processing - Maintenance and Field Services - Sales, Finance, and Administration | Revised Date <u>05/15/08</u> |
| Policy Number | SOP Title: <u>Tank Trailer & Confined</u> <u>Space Entry</u> | SOP Description: Defines the systems and procedures associated with the entry of confined spaces and tank trailers. |

1) SCOPE AND APPLICATION

- a) This sop applies to all CES Environmental employees who enter confined spaces.
- b) This is based on 29CFR1910 Permit-required confined spaces for General Industry; Final Rule. It has been adapted for our particular industry.

2) INTRODUCTION TO CONFINED SPACE ENTRY

- a) In January 1993 OSHA issued a regulation dealing specifically with work done inside confined spaces. Confined spaces are spaces which are especially dangerous to the untrained worker because of the limited access and egress routes.
- b) The risk of death or serious injury is not limited to the entrant but also to the rescuers. NIOSH issued a special alert to inform everyone to the fact that "more than 60% of the confined space fatalities occur among would-be rescuers." NIOSH also reported that during the 3 year period of 1974-1977 there were 276 confined space accidents which resulted in 234 deaths and 193 injuries.
- c) In recognizing that not all confined spaces are the same there are three distinctly different standards that we have established for work done in confined spaces. The three types of entry are: PERMIT REQUIRED

ENTRY, NON-PERMITREQUIRED ENTRY, and HOT WORK ENTRY. Permit required entries are for the most dangerous atmospheric conditions; non-permit entry is for entry when the atmosphere has been determined to be safe, and hot work entry is for the welding and grinding work done inside a confined space.

d) Because of the risks associated with confined space entry, entrance into confined space must only be attempted by trained personnel and failure to follow the SOP will result in serious disciplinary action up to and including termination of employment.

3) **DEFINITIONS**

- a) Acceptable entry conditions The conditions that must exist in a permit space to allow entry and to ensure that employees involved with a permit-required confined space entry can safely enter into and work within the space.
- b) Attendant An individual stationed outside one or more permit spaces who monitors the authorized entrants and who perform all attendant's duties assigned in CES 's permit space program.
- c) Authorized Entrant An employee who is authorized by CES to enter a permit space.
- d) **Blanking or blinding** The absolute closure of a pipe, line, or duct by the fastening of a solid plate (such as a spectacle blind or a skillet blind) that completely covers the bore and that is capable of withstanding the maximum pressure of the pipe, line or duct with no leakage beyond the plate.
- e) Confined space a space that:
 - i) Is large enough and so configured that an employee can bodily enter and perform assigned work; and
 - ii) Has limited or restricted means for entry or exit (for example, tanks, vessels, silos, storage bins, hoppers, vaults, and pits are spaces that may have limited means of entry); and
 - iii) Is not designed for continuous employee occupancy.
- f) *Emergency* Any occurrence (including any failure of hazard control or monitoring equipment) or event internal or external to the permit space that could endanger entrants.
- g) **Engulfment** The surrounding and effective capture of a person by a liquid or finely divided (flowable) solid substance that can be aspirated to cause death by

- filling or plugging the respiratory system or that can exert enough force on the body to cause death by strangulation, constriction, or crushing.
- h) *Entry* The action by which a person passes through an opening into a permit-required confined space. Entry includes ensuing work activities in that space and is considered to have occurred as soon as any part of the entrant's body breaks the plane of an opening into the space.
- i) *Entry permit* The written or printed document that is provided by CES to allow and control entry into a permit space and that contains information listed in paragraph f) of 1910.252.
- j) Entry supervisor The person (such as an employer, foreman, or crew chief) responsible for determining if acceptable entry conditions are present at a permit space where entry is planned, for authorizing entry and overseeing entry operations, and for terminating entry as required by this section. Note: Any entry supervisor also may serve as an attendant or as an authorized entrant, as long as that person is trained and equipped as required by this section for each role he or she fills. Also, the duties of entry supervisor may be passed from one individual to another during the course of an entry operation.
- k) *Hazardous atmosphere* An atmosphere that may expose employees to the risk of death, incapacitation, impairment of ability to self-rescue (that is, escape unaided from a permit space); injury, or acute illness from one or more of the following causes:
 - i) Flammable gas, vapor, or mist in excess of 10 percent of its lower flammable limit (LFL);
 - ii) Airborne combustible dust at a concentration that meets or exceeds its LFL; Note: This concentration may be approximated as a condition in which the dust obscures vision at a distance of 5 feet (1.52m) or less.
 - iii) Atmospheric oxygen concentration below 19.5 percent or above 23.5 percent;
 - iv) Atmospheric concentration of any substance for which a dose or a permissible exposure limit is published in Subpart G, Occupational Health and Environmental Control, or Subpart Z, Toxic and Hazardous Substances, of this part and which could result in employee exposure in excess of its dose or permissible exposure limit; Note An atmospheric concentration on any substance that is not capable of causing death, incapacitation, impairment of ability to self-rescue, injury, or acute illness due to its health effects is not covered by this provision.
 - v) Any other atmospheric condition that is immediately dangerous to life or health. Note: For air contaminants for which OSHA has not determined a dose or permissible exposure limit, other sources of information, such as Material Safety Data Sheers that comply with the Hazard Communication

Standard, 1910.1200 of this part, published information, and internal documents can provide guidance in establishing acceptable atmospheric conditions.

- 1) Hot work permit CES's written authorization to perform operations (for example, riveting, welding, cutting, burning, and heating) capable of providing a source of ignition.
- m) Immediately dangerous to life or health (IDLH) means any condition that poses an immediate or delayed threat to life or that would cause irreversible adverse health effects or that would interfere with an individual's ability to escape unaided from a permit space. Note: Some materials hydrogen fluoride gas and cadmium vapor, for example may produce immediate transient effects that, even if severe, may pass without medical attention, but are followed by sudden, possibly fatal collapse 12-72 hours after exposure. The victim "feels normal" from recovery from transient effects until collapse. Such materials in hazardous quantities are considered to be "immediately" dangerous to life or health.
- n) Inerting The displacement of the atmosphere in a permit space by a noncombustible gas (such as nitrogen) to such an extent that the resulting atmosphere is noncombustible. Note This procedure produces an IDLH oxygen-deficient atmosphere.
- o) Non-permit confined space A confined space that does not contain or, with respect to atmospheric hazards, have the potential to contain any hazard capable of causing death or serious physical harm.
- p) Oxygen deficient atmosphere An atmosphere containing less than 19.5 percent oxygen by volume.
- q) Oxygen enriched atmosphere An atmosphere containing more than 23.5 percent oxygen by volume.
- r) **Permit-required confined space** (permit space) A confined space that has one or more of the following characteristics:
 - i) Contains or has a potential to contain a hazardous atmosphere;
 - ii) Contains a material that has the potential for engulfing an entrant;
 - iii) Has an internal configuration such that an entrant could be trapped or asphyxiated by inwardly converging walls or by a floor which slopes downward and tapers to small cross section, or;
 - iv) Contains any other recognized serious safety or health hazard.
- s) **Permit system** CES's written procedure for preparing and issuing permits for entry and for returning the permit space to service following termination of entry.

- t) **Prohibited condition** Any condition in a permit space that is not allowed by the permit during the period when entry is authorized.
- u) Rescue service The personnel designated to rescue employees from permit spaces.
- v) **Retrieval system** The equipment (including a retrieval line, chest or full body harness, and lifting device or anchor) used for non-entry rescue of persons from permit spaces.
- w) **Testing** The process by which the hazards that may confront entrants of a permit space are identified and evaluated. Testing includes specifying the tests that are to be performed in the permit space. Note Testing enables employers both to devise and implement adequate control measures for the protection of authorized entrants and to determine if acceptable entry conditions are present immediately prior to, and during, entry.

4) GENERAL REQUIREMENTS FOR PERMITTED ENTRY

- a) **DEFINITION**
- b) A trailer is considered a permit space when:
 - i) Contains or has a potential to contain a hazardous atmosphere; or
 - ii) Contains any other recognized serious safety or health hazard.
- c) For other definitions see above.
- d) IDENTIFICATION OF OTHER COMPANY CONFINED SPACES Examples:
 - i) Cargo Vessels
 - ii) Storage Tanks
 - iii) Vats
 - iv) Diked Areas
 - v) Pits or Man holes
 - vi) Boilers
 - vii) Waste Water Tanks
- e) Survey and Labeling

Each facility must be surveyed and a log made of all confined spaces and if they are permit required or not.

All permit required spaces must be labeled as such.

5) HAZARD ASSESSMENT AND CONTROL

a) Atmospheric Hazards:

i) Testing:

Oxygen should always be tested first. Oxygen is needed for other tests to work properly.

Test the entire space. Top, Middle, and Bottom of each space entered. All entrants will always wear the CGI/O2 meter to provide continuous monitoring

Testing should be redone after each interruption in the entry of more two hours or when deemed necessary.

Always allow sufficient time for all testing devices to warm up. Always allow sufficient time for the testing device to register.

(1) Oxygen Deficiency/ Enrichment

Acceptable range is 19.5% to 23.5%. Air is about 21% Oxygen levels are tested using direct reading meters. Oxygen deficient or enriched atmospheres can be controlled by mechanical ventilation of the space.

(2) Flammable Gasses and Vapors

Measured as a percent of the Lower Flammable Limit (LFL) with a Combustible Gas Meter (CGI).

A hazardous atmosphere exists whenever a flammable gas or vapor exists in excess of 10% of its lower flammable limit.

Flammable atmospheres can be controlled by mechanical ventilation of the space.

(3) Toxic Gasses and Vapors

Measured in Parts Per Million (PPM) using electronic gas detectors or direct reading color metric tubes.

Each toxin will have a pre-determined Personal Exposure Limit (PEL) which should not be exceeded.

Toxic Gas atmospheres can be controlled by additional flushing or cleaning of the space.

(4) Ventilation

Atmospheric hazards can be controlled using mechanical ventilation.

Ventilation is done by blowing large volumes of fresh air into a space (supply ventilation) or by drawing large volumes of air out of a space (exhaust ventilation).

Non-permit entries require ventilation for five minutes prior to and during all entries.

Ventilation must draw air from a single outside air source. If this type system is not available the permit system must be followed.

b) Mechanical Hazards

- i) Tractor hooked to tank. Lock out tractor.
- ii) No tractor hooked to tank. Tag out fifth wheel.
- iii) Cleaning system in tank. Lock or Tag out system
- iv) Any mechanical or electrical system which could injure entrant if activated or energized during entry, Lock out Tag out, disconnect blank and bleed, and secure.

c) Electrical Hazards

- i) A special concern when entering wet spaces with power equipment and lights.
- ii) Lock out Tag out any equipment which could harm the entrant if energized.
- iii) Use Ground Fault Interrupt (GFI) devices in wet areas.

d) General Physical Hazards

- i) Temperature Extremes
- ii) Engulfment Hazards
- iii) Noise
- iv) Slick surfaces
- v) Falling objects

e) External Hazards

- i) Pedestrians or vehicles-Erect barriers
- ii) Ventilation- Ventilate only with clean air; beware of vehicle exhaust and other contaminants.

6) PERMITTED SPACE ENTRY INSPECTION PROCESS

NOTE: ALL OF THE REQUIREMENTS IN THIS SECTION MUST BE MET PRIOR TO ENTERING THE TRAILER.

- a) Only trained CES Environmental employees shall enter a permitted space.
- b) The trailer must first be thoroughly cleaned with the proper process for the specific commodity it hauled. Do not proceed with an entry until the commodity is known and the trailer is clean, if you are unable to determine the cleaning procedure and/or commodity report the problem to the Customer Service Account Manager or Area Manager.
- c) All trailers containing flammable or combustible commodities must be ventilated to less than 1% LEL before bringing onto the wash rack. If you are not familiar with the hazards associated with the commodity, refer to the MSDS, Chemical Dictionary, facility Commodity Tankwash System or Tank Wash Manager. Do Not Guess!
- d) Run a complete mechanical wash cycle on the trailer according to the cleaning procedure for that commodity.
- e) Ventilate the trailer for a minimum of five minutes.
- f) Test the atmosphere inside the trailer for the correct oxygen level (19.5% to 23.5), the absence of hazardous levels of carbon monoxide (TOX LESS THAN 35 ppm), and a lower explosive limit less than 1% using the air meter provided. Record the results of the test in the entry permit section of the tank wash form. Ensure that the air meter continues to monitor the atmosphere during all confined space entries. Ensure that the air meter has a current calibration. See section 5 for air meter operational details.
- g) Have the attendant (stand-by person) sign the entry permit and remain at the manhole attentive to your activities while you are inside the tank trailer.
 - i) Maintain a count of entrants.
 - ii) Communicate with the entrant.
 - iii) Remain at entrance to space at all times unless relieved by another attendant
 - iv) Order evacuation of space if a prohibited condition is observed or a sign or symptom of exposure to entrant is observed

- v) Prevent unauthorized entry
- vi) Summon rescue services at first the sign of an emergency
- vii) Perform non-entry rescue should entrant be unable to exit. DO NOT ENTER THE SPACE.
- h) Entry Supervisor
 - i) Verifies the permit is completed and all safety steps listed are taken then signs the permit.
 - ii) During entry, checks conditions to make sure they remain safe.
 - iii) Removes unauthorized people from area near space.
 - iv) Cancels the permit if conditions become unsafe or work is completed.
 - v) Note: The entry supervisor can act as the attendant.

i) Entrant:

- i) Communicate with the attendant.
- ii) Alert attendant of any symptom of exposure or prohibited condition.
- iii) Exit immediately when ordered by the attendant or at first sign of a prohibited condition or exposure.
- j) If the atmosphere in the trailer does no test safe levels, do the following:
 - i) Place the danger, hazardous atmosphere sign, across the manhole opening, and ventilate the trailer with fresh air.
 - ii) Allow the trailer to ventilate with the manhole and all valves open for a minimum of one hour or mechanically ventilate for fifteen minutes.
 - iii) Retest the trailer after the time limits in b) above.
- k) If the atmosphere in the trailer tests at a safe level:
 - i) Oxygen between 19.5 and 23.5%
 - ii) LEL less than 1%
 - iii) Carbon monoxide (TOX) less than 35 ppm.

Then:

 Ensure the attendant is at the manhole as you enter the tank and remains near the manhole.

- Ensure you are wearing your harness, lifeline, and respirator while in the trailer.
- Ensure you have the air meter hose in the trailer and the meter remains on while in the trailer.
- l) If an odor exists, ventilate the trailer until the odor dissipates. Use a fresh air supply respirator.

7) PERMITTED SPACE ENTRY PROCESS

- a) All requirements in section 6 have been met prior to entering the trailer.
- b) Anytime you are inside a tank and experience any kind of sickness, weakness, lightheadedness, or any other unusual or abnormal signs, get out of the tank immediately.
- c) Communication must be maintained with the attendant.
- d) Only approved, explosion proof lights may be used inside the tank.
- e) Rescue equipment must be immediately available to the attendant.
- f) The air meter must be continuously monitored while someone is inside the trailer.
- g) The entrant is in the proper uniform (harness attached to the life line.)
- h) Use a non-sparking ladder to enter the trailer.

8) GENERAL REQUIREMENTS FOR NON-PERMIT REQUIRED ENTRY

a) DEFINITION

- i) A space is considered a non-permit required space when:
 - (1) Does not contain nor have a potential to contain a hazardous atmosphere;
 - (2) Contains no material that has the potential for engulfing an entrant;
 - (3) Does not have an internal configuration such that an entrant could be trapped or asphyxiated by inwardly converging wall or by a floor which slopes downward and tapers to a smaller cross-section; and
 - (4) Contains no other recognized serious safety or health hazard.

ii) For other definitions see section 3 above.

b) PROCESS TO RENDER A CONFINED SPACE NON-PERMIT REQUIRED

- i) The trailer is cleaned physically and mechanically with an appropriate process for the commodity it contains, if you are unable to determine the cleaning procedure and/or commodity report the problem to the Tank wash Manager or Lead Tankwasher. Do not proceed with an entry until the commodity is known and the trailer is clean. All trailers containing flammable or combustible commodities must be ventilated to less than 1% LEL before being brought onto the wash rack. If you are not familiar with the hazards associated with the commodity, refer to the MSDS, Chemical Dictionary, facility Commodity Tankwash System or Tank Wash Manager. Do Not Guess!
- ii) The trailer is rinsed sufficiently to remove any residual cleaning solution.
- iii) The trailer is ventilated to remove excess moisture.
- iv) Verify the atmosphere is within acceptable limits using the air meter. Ensure the air meter is properly calibrated prior to use. The standard is:
 - (a) Oxygen between 19.5 and 23.5%
 - (b) LEL less than 1%
 - (c) Carbon monoxide (TOX) less than 35 ppm.

c) NON-PERMIT SPACE INSPECTION PROCESS

NOTE: ALL OF THE REQUIREMENTS IN THIS SECTION MUST BE MET PRIOR TO ENTERING THE TRAILER.

- i) All requirements in paragraph 8 b must be met.
- ii) All required information must be filled in on the work order in the permit section.
- iii) The atmosphere is within acceptable limits as measured by a properly calibrated air meter. The air meter must continue to monitor the atmosphere at all times during a trailer entry.

- iv) The work being performed in the trailer is in one of the following categories:
 - (1) trailer inspection
 - (2) cold water spraying
 - (3) removing films or residue using mild soaps, detergents, or physical scraping (pads, razors, brushes, steel wool)
 - (4) minor maintenance work such as PM's or visual tank inspection not to include welding
 - (5) other minor work approved by the Tankwash Manager or Maintenance Manager.
- v) Work not included in section iv above shall not be considered a nonpermit entry and must follow the procedures in section 7. Other work which could produce an atmospheric hazard shall not be considered a non-permit entry. Such as:
- vi) The use of harsh strippers, solvents, or other vapor producing material vii) Welding or other work which could create an atmospheric hazard
- viii) Work recognized as a serious safety or health hazard when performed in a confined space.

9) NON-PERMITSPACE ENTRY PROCESS

- a) All requirements in section 8 b and 8 c have been met prior to entering the trailer.
- b) Anytime you are inside a tank and experience and kind of sickness, weakness, lightheadedness, or any other unusual or abnormal signs, get out of the tank immediately.
- c) Communication must be maintained by using a Motion Sensing unit, Approved radio (explosion proof, 2-way), or other effective method to verify the health and safety of the entrant.
- d) Only approved, explosion proof lights may be used inside the tank.
- e) Rescue equipment must be immediately accessible to the entrance of the trailer.

- f) The air meter must be continuously monitored while someone is inside the trailer.
- g) The entrant is in the proper uniform (harness attached to the life line.)
- h) Use a non-sparking ladder to enter the trailer.
- Ventilation air will be continuously applied without affecting access out of the trailer through the manhole. Ventilation should occur through the vent caps.
- i) Entrant will be working without an attendant to monitor them.
- k) Entrant will inspect the entire length of all cargo tanks prior to doing any work. If any hazard is noted the entrant will immediately exit the tank and remove the hazard.
- 10) Documentation
- 11) Rescue and reporting
 - a) Self Rescue:
 - i) Entrant or attendant recognizes a forbidden condition or symptom and the entrant exits the space.
 - ii) Most successful type rescue
 - b) Non-Entry Rescue
 - i) Entrant shows symptoms of exposure and cannot exit the space. The attendant or anyone hearing an activated PASS device activates the emergency system.
 - ii) The attendant or summoned employee operates the retrieval device and pulls the entrant from the space.
 - c) Outside Rescue Teams
 - i) Provided by the local fire department
 - ii) Must be notified in writing of intent to use their services
 - iii) Must be notified of hazards to expect
 - iv) Must be provided access to all spaces to develop preplans and practice rescue operations
 - v) Drill and assess results annually.

d) Reporting

- i) All rescues must be reported in writing to the manager.
- ii) The manager must authorize re-entry

12) Toxic testing

- i) Any tank which previously contained a chemical or constituent shown on the table of Z listed chemicals must undergo a color metric tube toxic test.
- ii) For any tank which previously contained a chemical or constituent not shown on the table of Z listed chemicals le, CARBON MONOXIDE will be indicated on the entry permit as the toxic material tested
- iii) Testing will be done at the same locations on a tank as the Oxygen/
 Flammability/ Carbon Monoxide testing using the 10 foot extension hose attached to the pump.
- iv) Toxic testing on tanks without clean outs will be done concurrently with the Oxygen
- v) From the MSDS or Commodity system determine the chemical or constituents contained in the last product hauled by the tank.
- vi) Determine if the chemical or any constituents appears on table of Z listed chemicals.
- vii) If the chemical or any constituents appears on the table of Z listed chemicals. Determine the proper color metric tube to be used and the minimum number of pump strokes.
- viii) If a product has several constituents select the tube for the highest percentage constituent for which there is a tube available at the facility. Testing is required for one constituent only.
- ix) Indicate the chemical being toxic tested and it's permissible exposure limit from the MSDS
- x) If no tubes are available for any of the chemicals or constituents, entry is NOT ALLOWED and you should contact your facility manager
- xi) Break both ends off the glass tube by inserting the ends into the hole located in the body of the pump and snapping the tips

- xii) Insert the tube into the rubber sling located on the end of the 10 foot extension hose with the blue arrow pointing TOWARD the pump
- xiii) Drop the hose into the trailer and draw the first pump stroke. Watch the red flow indicator on the end of the pump. When it pops up the pump stroke is complete and you can do the next pump stroke if required.
- xiv) As you are performing the pump stroke raise and lower the hose end containing the tube within the trailer to test the entire space. Be certain no to remove the hose end from the trailer before a pump stroke is complete.
- xv) Once the minimum number of pump strokes are completed in the first testing location. Only one additional pump stroke is necessary at subsequent testing locations
- xvi) After the minimum number of pump strokes for a tube is completed, examine the tube for a color change after each stroke is completed.
- xvii) REMEMBER a pump stroke may take 30 seconds. Wait for the red button to pop up.
- xviii) Any color change in the color metric tube indicates a toxic atmosphere and entries NOT ALLOWED the trailer must be recleaned or ventilated until all testing meets allowable conditions.

FOSTER PLACE STATION HOUSTON, Texas 770219998 4841490027-0095

05/13/2008 (800)275-8777 03:28:57 PM

| | Sales Receipt | |
|---|---------------|---------------------|
| Product Description | Sale Unit | Final Price |
| HOUSTON TX 7 Zone-1 First Large Env 6.50 oz. | | \$1.85 |
| Return Ropt Card) | (Green | \$2.20 |
| Certified Label #: | 70053110000 | \$2,70 304912284 |
| Issue PVI: | | *6.75 |

======== \$6.75

Paid by:

Total:

Cash \$7.00 Change Due: -\$0.25

Order stamps at USPS.com/shop or call 1-800-Stamp24. Go to USPS.com/clicknship to print shipping labels with postage. For other information call 1-800-ASK-USPS.

Bill#:1000500456859

Clerk:03

Go to: http://gx.gallup.com/pos

TELL US ABOUT YOUR RECENT POSTAL EXPERIENCE

Customer Copy



| - | |
|--|---|
| SENDER: COMPLETE THIS SECTION | COMPLETE THIS SECTION ON DELIVERY |
| Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. Print your name and address on the reverse so that we can return the card to you. Attach this card to the back of the mailpiece, or on the front if space permits. | A. Signature Agent X |
| 1. Article Addressed to: US Department of Labor OC Schonal Health and Safety I in 15tration 1 12 -5 EL Camino Real Suite | If YES, enter delivery address below: No |
| | 3. Service Type |
| Halston, TIMOSS | ☐ Registered ☐ Return Receipt for Merchandise ☐ Insured Mall ☐ C.O.D. |
| | 4. Restricted Delivery? (Extra Fee) |
| 2. Article Number (Transfer from service label) 7005 311 | 0 0003 0491 2264 |
| PS Form 3811 February 2004 - Domestic Pet | uro Pocolet |

UNITED STATES POSTAL SERVICE

First Class Mail
Postage & Fees Pend
USPS
Pergit No. G. 10

Sender: Please print your name, address, and ZIP+4 in this box *

(Karl Guidry)

CES Environmental Services Inc.

4904 Griggs Rd.

Houston TX TD21

EPAHO043000173

Farrier Riley 5-22-08





TEXAS DEPARTMENT OF INSURANCE DIVISION OF WORKERS' COMPENSATION

ΒY

Si prefiere hablar con una persona de habla hispana acerca de esta correspondencia o de su reclamo, sírvase llamar al 1-800-252-7031.

CES ENVIRONMENTAL INC 4904 GRIGGS RD HOUSTON, TX 77021-3208 August 28, 2008

Claim No: (b) (4)

Docket No: 08272108-01-BR

Carrier No: 99J0000533279

Employee: FARRIER RILEY

Employer: CES ENVIRONMENTAL INC

CES ENVIRONMENTAL SERVICES INC

Date of

Injury: May 22, 2008

BENEFIT REVIEW CONFERENCE

INFORMATION ONLY, AND DOES NOT

REQUIRE ANY ACTION ON YOUR PART.

DATE:

August 29, 2008

THIS LETTER IS SENT TO YOU FOR YOUR

TIME: PLACE: 10:00 AM

TDI -DIV WORKERS' COMPENSATION 2440 TEXAS PARKWAY, SUITE 240

MISSOURI CITY, TX 77489

(281) 403-7050

CONTESTED CASE HEARING:

DATE:

TO BE DETERMINED TO BE DETERMINED

TIME:

PLACE: TO BE DETERMINED

The proceeding(s) in the claim and docket number shown above have been canceled for the reason shown below:

- () 1. The disputed issue(s) have been resolved by agreement/settlement; or,
- (x) 2. A request to cancel or reschedule has been granted.

If you have any questions, please contact the Division Field Office handling the claim at the address or telephone number shown below.

Sincerely,

TD! -DIV WORKERS' COMPENSATION 2440 TEXAS PARKWAY, SUITE 240 MISSOURI CITY, TX 77489 (281) 403-7050

| THIS LETTER WAS ALSO SENT | TO THE FOLLOWING |
|---------------------------|------------------|
| FARRIER RILEY | |
| (b) (4) | |
| | |
| | |

TEXAS MUTUAL INSURANCE CO PO BOX 12029 AUSTIN, TX 78711-2029 OGLETREE ABBOTT LAW FIRM LLP FYODOR D. CLAY 12600 N FEATHERWOOD DR STE 200 HOUSTON, TX 77034-4440 Send to workers' compensation carrier:

TEXAS MUTUAL 713-316-2191

(Name and fax number of carrier)



| İ | CLAIM# 99J0000533279 | |
|---|----------------------|--|
| | CARRIER'S CLAIM # | |

| □ Initial | □ Amended |
|-----------|-----------|
| | |

EMPLOYER'S WAGE STATEMENT

The Texas Workers' Compensation Act and Workers' Compensation rules require an employer to provide an Employer's Wage Statement to its workers' compensation insurance carrier (carrier) and the claimant or the claimant's representative, if any. The purpose of the form is to provide the employee's wage information to the carrier for calculating the employee's Average Weekly Wage (AWW) to establish benefits due to the employee or a beneficiary.

The AWW is based on the wages the employee earned in the 13 weeks immediately preceding the date of injury (or the wage a similar employee earned if the employee did not work the full 13-week period). "Wages" include all forms of remuneration payable to an employee for personal services, including fringe benefits. To simplify filing, employers may file wages in a monthly, biweekly, or weekly manner as discussed below.

NOTE - An employer who fails without good cause to timely file a complete wage statement as required by the Texas Workers' Compensation Act, Texas Labor Code, Section 408.063(c) and Worker's Compensation Rule 120.4 may be assessed an administrative penalty not to exceed \$500.00 for an initial offense and not to exceed \$10,000.00 for a repeated administrative violation.

The employer shall timely file a complete wage statement in the form and manner prescribed by the Division.

- (1) The wage statement shall be filed ("filed" means received) with the carrier, the claimant, and the claimant's representative (if any) within 30 days of the earliest of:
 - (A) the employee's eighth day of disability;
 - (B) the date the employer is notified that the employee is entitled to income benefits;
 - (C) the date of the employee's death as a result of a compensable injury.
- (2) The wage statement shall also be filed with the Division within seven days of receiving a request from the Division (Only When Requested).
- (3) A subsequent wage statement shall be filed with the carrier, employee, and the employee's representative (if any) within seven days if any information contained on the previous wage statement changes (such as if the employer discontinues providing a nonpecuniary wage that was initially continued after the date of injury).

All applicable DWC rules can be found at www.tdi.state.tx.us

| EMPLOYEE AN | D EMPLOYER INFORMATION | <u> </u> |
|--|--|--|
| RILEY, FA | | Employer's Business Name: CES ENVIRONMENTAL SERVICES |
| (b) (4) | | Employer's Mailing Address (Street or P.O. Box): 4904 GRIGGS RD. |
| (b) (4) | 710.0 | City: State: ZIP Code: 77021 |
| XXX-XX | (last four digits): | 76-0592985 |
| (b) (4) | Date of Injury: 5-22-08 | Name and Phone # of Person Providing Wage Information: KARL GUIDRY |
| | te, the employee is not back at work. OR sturned to work on and is working: | I HEREBY CERTIFY THAT this wage statement is complete, accurate, and |
| ☐ without restriction week/month (circ | ns and is earning wages of \$ per | complies with the Texas Workers' Compensation Act and applicable rules, and the listed wages include all pecuniary and nonpecuniary wages paid for (earned in) the 13 weeks prior to the date of injury (as described on page 2) and I understand that making a misrepresentation about a workers' |
| | requires the employer file the Supplemental Report of 5) to report changes in Work Status and Post-Injury | compensation claim is a crime that can result in fines and/or imprisonment. Signature: |
| | STATUS AT TIME OF IN URY (Check A | |

- Full-time: employee who regularly works at least 30 hours per week and whose schedule is comparable to other employees of the company and/or other employees in the same business or vicinity who are considered full-time.
- Seasonal: employee who as regular course of conduct engages in seasonal or cyclical employment that may or may not be agricultural in nature and that does not continue throughout the year.
- ☐ Part-time: Regular Course of Conduct: employee whose work history for the 12-month period preceding the injury shows the person only worked part-time during that period.
- ☐ Part-time: Not Regular Course of Conduct: employee whose work history for the 12-month period preceding the injury shows part-time and full time work during that period.
- Apprentice: employee who is learning a skilled trade or art by practical experience under the direction of a skilled crafts person or artisan.
- ☐ Minor: employee less than 18 years of age and not emancipated by marriage or judicial action who is also an apprentice, trainee or student.
- ☐ Student: employee enrolled in a course of study in high school, college or other institute of higher education or technical training.
- ☐ Trainee: employee undergoing systematic instruction and practice in some art, trade or profession with a view towards proficiency in it.

SAME OR SIMILAR EMPLOYEE?

The wage information on this form is for:

☐ The Injured Employee OR ☐ A Similar Employee (NOTE - If requested by the Division, the employer shall identify the similar employee whose wages were provided.)

if the employee was not employed for 13 continuous weeks before the date of injury, report the wages of an employee who has training, experience, skills & wages comparable to the injured employee AND who performs services/tasks comparable in nature and in number of hours. If no similar employee exists, report the limited available wages earned by the injured employee prior to the injury.

NOTE TO INJURED EMPLOYEE - If you were injured on or after 7/1/02, and had employment with more than one employer on the date of injury, you can provide your insurance carrier with wage information from your other employment for the carrier to include in your AWW and this may affect your benefits. Contact your carrier for additional information or call the Division at (800) 252-7031. You can also read rule 122.5 at www.tdi.state.tx.us.



WAGE INFORMATION INSTRUCTIONS

Employee Name: RILEY, FARRIER

Social Security #: XXX~XX

Nonpecuniary Wages include all wages paid to the employee in a form other than money. These include, but are not limited to, the

b) (4)

^{bale of Injury:} 5-22**-**08

- The employer shall report all wages earned in the 13 weeks immediately preceding the date of injury. If the employee is paid on a monthly or semi-monthly basis, the employer may provide wages for the 3 months preceding the date of injury. Monthly wages may also be converted to weekly wages by dividing the gross monthly amount by 4.34821. If the employee is paid on a biweekly basis, the employer may provide the wages for the 14 weeks preceding the date of injury. When setting the periods to report, the employer may adjust the reporting period backward slightly (up to six days) to line up the reporting timeframes with the employer's natural pay cycle. However, the employer shall not report wages earned on or after the date of injury.
- If reporting weekly earnings, use all 13 Period Columns below. If reporting 3 months of earnings, either convert the wages to weekly earnings or use the first 3 Period Columns. If reporting 14 weeks of biweekly earnings, use the first 7 Period Columns. In all cases, indicate the dates that each period covers.

| PECUNIARY WAGE I | NFORM | ATION | | hourly, we commission commission use of the | ekly, biweel ons. Earnin ons) need to employee's | kly, monthly gs are repo be prorated equipment | t, etc. wages orted in the or Pecuniary or for paying | s; salary, tip periods the wages don g helpers or | s/gratuities; y are earne t include pa to reimburse | piecework d, NOT who yments mad e for travel o | compensations they are less than they are less than they are less than the less than t | on, monetar paid and si ployer to rein Consider as | y allowance ome (such mburse the e earnings an | re not limited to: s; bonuses; and as bonuses and employee for the nounts from paid not used. |
|---|---------|-------|-------|--|---|---|--|--|--|---|--|---|---|---|
| PERIOD # (Week #, Month #, or Bi-Week #) | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | |
| FROM DATE: | 2/17 | 2/24 | 3/02 | 3/09 | 3/16 | 3/23 | 3/30 | 4/06 | 4/13 | 4/20 | 4/27 | 5/04 | 5/11 | |
| TO DATE: | 2/23 | 3/01 | 3/08 | 3/15 | 3/22 | 3/29 | 4/05 | 4/12 | 4/19 | 4/26 | 5/3 | 5/10 | 5/17 | TOTALS |
| # HOURS WORKED: | 44:36 | 53:13 | 44:27 | 63:26 | 53:04 | 58:05 | 58:22 | 68:25 | 63:19 | 55:30 | 47:16 | 47:02 | 48. | 703.25 |
| GROSS WAGES EARNED: | (b) (4) | | | | , | | | | | | | | | |

| Nonpecuniary Wage Type | Provide | loyer ed Prior jury? | Spe | Specify Value Or Amount Earned in Each Reported Period For Each Benefit Provided Prior To Injury (Use the same periods as used above) | | | | | | | | | | Will Employer Continue To Provide? | | Date Benefit Suspended (if suspended) | | |
|---------------------------|---------|----------------------------|-----|---|---|---|---|---|---|---|---|----|----|--|----|---------------------------------------|----|--|
| | YES | NO | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | YES | NO | |
| Health Insurance | | 1 | | | | | | | | | | | | | | | | |
| Laundry/ Cleaning | | | | | | | | | † | | | | | | | | | |
| Clothing/ Uniforms | | | | | | i | | | | | | | | | | | | |
| Lodging/ Housing/ | | | | | | | | | | | | | | | | | | |
| Food/ Meals | | | ~ | | | | | | | | | | | | | | | |
| Vehicle/ Fuel | | | | | | | | | | | | | | | | | | |
| Other | | | | | | | | | | | | | | | | | | |





4904 Griggs Road Houston, TX 77021 Phone: (713) 676-1460

(713) 676-1676



Texas Mutual To:

From:

Karl Guidry

Fax:

1-512-224-3889

Pages:

1 Page to follow

Attn:

Debbie Garrett

Date:

July 17, 2008

See attached documentation regarding our employee Farrier Riley.

Karl Guidry CES Environmental Services, Inc. HSE Manager 4904 Griggs Rd Houston, Texas 777021

******* -IND. XMT Journal- ********* Date JUL-17-2008 **** Time 09:39 ******

Date/Time = JUL-17-2008 09:38

Journal No. = 145

Comm. Result = OK

Page(s) = 002

Duration = 00:00:26

File No. = 722

Mode = Memory Transmission

Destination = 15122243889

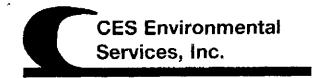
Received ID =

Resolution = Fine

-CES ENVIROMENTAL -

***** DP-C264 **************

- **** - 7137488664- *******



4904 Griggs Road Houston, TX 77021 Tel. (713) 676-1460 Fax. (713) 676-1676

July 16, 2008

To: Farrier Riley
From: Ryan Thomas

Dear Mr. Riley,

The purpose of this letter is to inform you that, in the best interest of CES Environmental Services, Inc., your employment is being terminated as of Wednesday July 16, 2008 at 7:00pm.

Please contact the Human Resources Office if you have questions about your benefits or any other matters pertaining to your employment with CES Environmental Services, Inc. You final paycheck will be ready on Friday July 18, 2008. Please be sure to turn in your company cell phone, uniforms and gate pass.

We appreciate all of your hard work and dedication you gave to CES Environmental Services, Inc. and wish you the best in your future.

Sincerely,

Ryan Thomas, Director of Logistics and Customer Service

CES Environmental Services, Inc.



TEXAS DEPARTMENT OF INSURANCE DIVISION OF WORKERS' COMPENSATION

RECEIVED
AUG 1 4 2008

Si prefiere hablar con una persona de habla hispana acerca de esta correspondencia o de su reclamo, sírvase llamar al 1-800-252-7031.

CES ENVIRONMENTAL INC 4904 GRIGGS RD HOUSTON, TX 77021-3208 August 12, 2008

Claim No: (b) (4)

Docket No: 08272108-01-BR

Carrier No: 99J0000533279
Employee: FARRIER RILEY

Employer: CES ENVIRONMENTAL INC

CES ENVIRONMENTAL SERVICES INC

Date of

Injury: May 22, 2008

THIS LETTER IS SENT TO YOU FOR YOUR INFORMATION ONLY, AND DOES NOT REQUIRE ANY ACTION ON YOUR PART.

BENEFIT REVIEW CONFERENCE

DATE: August 29, 2008

TIME: 10:00 AM

PLACE: TDI -DIV WORKERS' COMPENSATION

2440 TEXAS PARKWAY, SUITE 240

MISSOUR! CITY, TX 77489

(281) 403-7050

CONTESTED CASE HEARING:

TENTATIVE DATE: TO BE DETERMINED TIME & PLACE - TO BE DETERMINED

THIS CLAIM HAS BEEN SET FOR A BENEFIT REVIEW CONFERENCE

You are required to appear at this conference at the time and place stated above. The parties will attempt to resolve any disputes about this claim. A Division Ombudsman will contact unrepresented employees within two weeks to offer assistance in preparing for the conference.

The Benefit Review Conference is an informal meeting between an injured employee, the employee's designated representative (if any), and a representative of the insurance carrier. The employer is also entitled, but not required, to attend the conference. A Benefit Review Officer, who is an impartial Division employee, will also be present and will assist the parties in resolving the dispute. No testimony will be taken and no recording will be made.

The Benefit Review Officer will summarize the results of the conference. If all disputes are not resolved at this conference, the Division will hold a Contested Case Hearing. You will be advised by separate correspondence of the date, time, and location of the Contested Case Hearing.

Not later than 14 days before the conference, you must provide to all other parties and the Division field office handling the claim—copies of all written information relevant to the disputed issue or issues. If it is not possible to mail the information in time, bring enough copies to the conference to give to all parties.

if you wish to cancel or reschedule this conference, you must contact the Field Office at the address or telephone number below. A request to cancel or reschedule this conference must be made within 10 days after you receive this notice. A request received after 10 days may not be granted unless the Division — determines there was good cause for the delay.

You are required to attend this conference. Failure to attend may result in an Administrative Violation and a penalty up to a maximum of \$500.

Sincerely,

TDI -DIV WORKERS' COMPENSATION 2440 TEXAS PARKWAY, SUITE 240 MISSOURI CITY, TX 77489 (281)403-7050

THIS LETTER WAS ALSO SENT TO THE FOLLOWING:

FARRIER RILEY 12 OLD PRESIDIO DR MANVEL, TX 77578-5601

OGLETREE ABBOTT LAW FIRM LLP FYODOR D. CLAY 12600 N FEATHERWOOD DR STE 200 HOUSTON, TX 77034-4440

TEXAS MUTUAL INSURANCE CO PO BOX 12029 AUSTIN, TX 78711-2029



4904 Griggs Road Houston, TX 77021 Phone: (713) 676-1460

Fax: (713) 676-1676



To: Texas Mutual From: Karl Guidry

Fax: 1-512-224-3889 Pages: 5 Pages to follow

Attn: Debbie Garrett Date: July 15, 2008

See attached documentation regarding our employee Farrier Riley. Per your request we have submitted alternate wage data for another employee with similar pay and work schedule of Riley.

Karl Guidry CES Environmental Services, Inc. HSE Manager 4904 Griggs Rd Houston, Texas 777021

Received ID =

Resolution = Fine

-CES ENVIROMENTAL -

***** DP-C264 ************** - - ***** - 7137488664- ********



Claim & Information Services P.O. Box 12029 Austin, TX 78711-2029 1-800-859-5995 (512) 224-3800

102 10 2008

(512) 224-3889

July 7, 2008

C E S ENVIRONMENTAL SERVI 4904 GRIGGS RD HOUSTON, TX 77021-3208

Re:

Claim #:

Employee:

Soc. Sec.:

Employer:

C E S ENVIRONMENTAL SERVI

Date of Injury: 05/22/2008 DWC#:

08272108

FARRIER RILEY

Dear C E S ENVIRONMENTAL SERVI,

Thank you for submitting the attached Wage Statement. We have reviewed the form and have found information that must be changed to meet the requirements of the Division of Workers' Compensation. Please make the following corrections:

NEED WAGES 13 WEEKS PRIOR TO THE DATE OF INJURY, NOT INCLUDING THE DATE OF INJURY OR WE NEED A SAME OR SIMILIAR EMPLOYEE EARNINGS 13 WEEKS PRIOR TO THE DATE OF INJURY, NOT INCLUDING THE DATE OF INJURY.

Please note that the salary history cannot include, nor go beyond, the date of injury.

Thank you for your prompt attention to this matter. If you have any questions, please call me at I-800-859-5995 ext. 2243.

Sincerely,

Debbie K Garrett WORKERS' COMPENSATION SPEC II

Enclosure: Wage Statement

| Send to workers' compensation carrier | 1 |
|---------------------------------------|---|
| (Name and fat number of corner) | |



| TWCC# | |
|-------------------|--|
| CARRIER'S CLAIM # | |
| | |

| ☐ Initial ☐ Amended | EMPLOYER'S WAGE STATEMEN? |
|---------------------|---------------------------|
|---------------------|---------------------------|

The Texas Workers' Compensation Act and Commission rules require an amptoyer to provide an Employer's Wage Statement to life workers' compensation insurance certier (carrier) and the claimant or the claimant corposentative, if any. The purpose of the form is to provide the employer's wage information to the carrier for calculating the employee's Average Weekly Wage (AWW) to establish banefits due to the employee or a beneficiary.

The AWW is based on the wages the employee earned in the 13 weeks immediately preceding the date of injury (or the wage a similar employee samed if the employee did not work the full 13-week period). "Weges" include all forms of remuneration payable to an employee for personal services, including fringe benefits. To simplify filling, employers may file wages in a monthly, biweekly, or weekly mather as discussed below.

NOTE - An employer who falls without good cause to timely file a complete wage statement as required by the Texas Workers' Compensation Act. Texas Lebor Code. Section 408.083(a) and Commission Rule 120.4 may be assessed an administrative penalty not to exceed \$500.00 for an initial offense and not to exceed \$10,000.00 for a repasted administrative violation.

The employer shall timely file a complete wage statement in the form and manner prescribed by the Commission.

- (1) The wage statement shall be filed "filed" means received) with the carrier, the claimant, and the claimant's representative (if any) within 30 days of the sartiest of:
 - (A) the employee's eightn day of disability:
 - (B) the date the employer is notified that the employee is entitled to income penetits:
 - (C) the date of the employee's death as a result of a compensable injury.
- (2) The wage statement shall also be filed with the Commission within seven days of receiving a request from the Commission (Only When Requested).
- (3) A subsequent wage statement shall be filled with the carter, employee, and the employee's representative (if any) within seven days if any information contained on the previous wage statement changes (such as if the employer discontinues providing a nonpecuniary wage that was initially continued ofter the date of injury).

All applicable TWCC rules can be found at www.twco.state.tx.ua

| EMPLOYEE AND EMPLOYER INFORMATION | |
|--|---|
| Employee's Name (Last, First, M.I.). Rile: Faccier D | Employer's Business Name: CES Environmental Services Suc Employer's Malling Address (Street or P.O. Box): |
| (b) (4) | Employer's Mailing Address (Street or P.O. Box): 4904 Griggs Rd City: State: ZIP Code: |
| City: State: ZIP Code: | City: State: ZiP Code: |
| (b) (4) | 1 4 JOLISTON TX 17021 |
| Social Security Number: | Radoral Tax I.D. Number |
| (b) (4) | 110-0592985 |
| (b) (4) Date of Injury: | Name and Phone # of Person Providing Wage Information: |
| As of today's date, the employee is not back at work. OR The employee returned to work on and is workin without restriction. OR with restrictions and is earning wages of \$ pr week/month (circle one). | and the field wages include all pecuniary and nonpecuniary wages paid for (earned in) the 13 weeks prior to the date of injury (as described on page 2) and 1 understand that making a misrepresentation about a workers' compensation claim is a crime that can result in these and/or imprisonment. |
| NOTE — Rule 120,3 requires the amployer file the Supplemental Report Injury (TWCC-ti) to report changes in Work Status and Post-Injury Esmings | |
| EMPLOYMENT STATUS AT TIME OF INJURY (Clinic | k Att That Apply) |
| Fig. 11 stores and a second super super second super super at 1 months at 1 mo | Course of Conduct Tallers and the first the |

Full-time: employee who requirity works at least 30 hours per week and whose schedule is comparable to other employees of the company and/or other employees in the same business or widn'tly who are considered full-time.

Sessional: employee who as regular course of conduct engages in seasons! or cyclical employment that may or may not be agricultural in nature and that does not continue throughout the year.

Part-time: Regular Course of Conduct employee whose work history for the 12-month period preceding the injury shows the person only worked part-time during that pariod.

Part-time: Not Regular Course of Conduct: employee whose work history for the 12-month period preceding the injury shows part-time and full time work during that period.

Apprentice: employee who is learning a skilled trade or an by practical experience under the direction of a skilled crafts person or artisan.

Minor: employee less than 18 years of age and not emandpated by marriage or judicial action who is also an apprentice, trainee or atudent.

atudent:

| 3tudent: amployee enrolled in a course of aludy in high school, college or other insultate of higher education or technical training.

Traines: employee undergoing systematic instruction and practice in some an, trade or profession with a view towards profeseion with a view towards profeseion.

SAME OR SIMILAR EMPLOYEE?

The wage information on this form is for:

The Injured Employee OR A Similar Employee (NOTE - II requested by the Commission, the employer shall identify the similar employee whose wages were provided.)

If the employee was not employed for 13 continuous weeks before the date of injury, report the wages of an employee who has training, exparience, skills & wages comparable to the injured employee AND who performs services/hashes comparable in nature and in number of hours. If no similar employee exists, report the limited available wages earned by the injured employee prior to the injury.

NOTE TO INJURED EMPLOYEE - If you were injured on or effer 7/1/02, and had employment with more than one employer on the date of injury, you can provide your insurance carrier with wage information from your other employment for the corrier to include in your AWW and this may affect your benefits. Contact your carrier for additional information or call the Commission at (800) 282-7031. You can also read rule 122.5 at www.twcc.atate.ux.us.

TWGG-3 (Rev. 07/04) Page 1 of 2



TEXAS WORKERS' COMPENSATION COMMISSION

RECEIVED TIME JUN. 26. 2:53PM

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| TO DATE. | | - i | 1/19 | 4/20 | 5/3 | 5/10 | 5/ | 7 5/ | ш | 5/31 | 4/7 | 6/14 | 4/2 | 14 | 28 | | | TOTALS |
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| Send to | workers' | compen | sation carr | ier: | |
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| TWCC # |
|-------------------|
| CARRIER'S CLAIM # |

| □Initial □ Amended E | MPLO | OYER'S ' | WAGE | STA | TEMENT |
|-----------------------------|------|----------|------|-----|--------|
|-----------------------------|------|----------|------|-----|--------|

The Texas Workers' Compensation Act and Commission rules require an employer to provide an Employer's Wage Statement to its workers' compensation insurance carrier (carrier) and the claimant or the claimant's representative, if any. The purpose of the form is to provide the employee's wage information to the carrier for calculating the employee's Average Weekly Wage (AWW) to establish benefits due to the employee or a beneficiary

The AWW is based on the wages the employee earned in the 13 weeks immediately preceding the date of injury (or the wage a similar employee earned if the employee did not work the full 13-week period). "Wages" include all forms of remuneration payable to an employee for personal services, including fringe benefits. To simplify filing, employers may file wages in a monthly, biweekly, or weekly manner as discussed below.

NOTE - An employer who fails without good cause to timely file a complete wage statement as required by the Texas Workers' Compensation Act, Texas Labor Code, Section 408.063(c) and Commission Rule 120.4 may be assessed an administrative penalty not to exceed \$500.00 for an initial offense and not to exceed \$10,000.00 for a repeated administrative violation.

The employer shall timely file a complete wage statement in the form and manner prescribed by the Commission.

- (1) The wage statement shall be filed ("filed" means received) with the carrier, the claimant, and the claimant's representative (if any) within 30 days of the earliest of:

 - (A) the employee's eighth day of disability; (B) the date the employer is notified that the employee is entitled to income benefits:
 - (C) the date of the employee's death as a result of a compensable injury.
- (2) The wage statement shall also be filed with the Commission within seven days of receiving a request from the Commission (Only When Requested).
- (3) A subsequent wage statement shall be filed with the carrier, employee, and the employee's representative (if any) within seven days if any information contained on the previous wage statement changes (such as if the employer discontinues providing a nonpecuniary wage that was initially continued after the date of injury).

All applicable TWCC rules can be found at www.twcc.state.tx.us

| | | <u> </u> | | | |
|--|---|--|-------------------------|-----------|--|
| EMPLOYEE AND EMPLOYER INFORMATION | | | | | |
| Employee's Name (Last, First, M.I.): | | Employer's Business Name: | | | |
| Employee's Mailing Address (Street or P.O. Box): | | Employer's Mailing Address (Street or P.O. Box): | | | |
| City: State: ZIP Code: | | City: | State: | ZIP Code: | |
| Social Security Number: | Federal Tax I.D. Number: | | | | |
| Date of Hire: Date of Injury: | | Name and Phone # of Per | son Providing Wage Info | ormation: | |
| As of today's date, the employee is not back at work. O The employee returned to work on and is without restriction. OR with restrictions and is earning wages of \$ week/month (circle one). NOTE — Rule 120.3 requires the employer file the Supplementa | I HEREBY CERTIFY THAT this wage statement is complete, accurate, and complies with the Texas Workers' Compensation Act and applicable rules, and the listed wages include all pecuniary and nonpecuniary wages paid for (earned in) the 13 weeks prior to the date of injury (as described on page 2) and I understand that making a misrepresentation about a workers' compensation claim is a crime that can result in fines and/or imprisonment. | | | | |
| Injury (TWCC-6) to report changes in Work Status and Post-Injury E | | Signature: | | Date: | |
| least 30 hours per week and whose schedule is comparable to other employees of the company and/or other employees in the same business or vicinity who are considered full-time. Seasonal: employee who as regular course of conduct engages in seasonal or cyclical employment that may or may not be agricultural in nature and that does not continue throughout the least some period precedent where the continue throughout the least some period precedent where the continue throughout the least some period precedent where the company and/or other employees where the company and/or other employees in the same business or worked part-least some period precedent worked part-least some period precedent period precedent worked part-least some period precedent period period precedent period precedent period precedent period period precedent period period period period period period precedent period perio | In Course of Conduct: history for the 12-month ury shows the person only that period. Jular Course of Conduct: history for the 12-month ury shows part-time and full Minor: employee less than 18 years of age and not emancipated by marriage or judicial action who is also an apprentice, trainee or student. Student: employee enrolled in a course of study in high school, college or other institute of higher education or technical training. | | | | |
| The wage information on this form is for: The Injured Employee OR A Similar Employee (Note that the commission, the employer shall identify employee whose wages were provided.) | If the employee was not employed for 13 continuous weeks before the date of injury, report the wages of an employee who has training, experience, skills & wages comparable to the injured employee AND who performs services/tasks comparable in nature and in number of hours. If no similar employee exists, report the limited available wages earned by the injured employee prior to the injury. | | | | |

NOTE TO INJURED EMPLOYEE - If you were injured on or after 7/1/02, and had employment with more than one employer on the date of injury, you can provide your insurance carrier with wage information from your other employment for the carrier to include in your AWW and this may affect your benefits. Contact your carrier for additional information or call the Commission at (800) 252-7031. You can also read rule 122.5 at www.twcc.state.tx.us



TWCC-3 (Rev. 07/04) Page 1 of 2

TEXAS WORKERS' COMPENSATION COMMISSION

| MACE | INFORM. | A TION II | MCTDII | PHOLES |
|------|---------|-----------|--------|--------|

Employee Name:

Social Security #:

Date of Injury:

- The employer shall report all wages earned in the 13 weeks immediately preceding the date of injury. If the employee is paid on a monthly or semi-monthly basis, the employer may provide wages for the 3 months preceding the date of injury. Monthly wages may also be converted to weekly wages by dividing the gross monthly amount by 4.34821. If the employee is paid on a biweekly basis, the employer may provide the wages for the 14 weeks preceding the date of injury. When setting the periods to report, the employer may adjust the reporting period backward slightly (up to six days) to line up the reporting timeframes with the employer's natural pay cycle. However, the employer shall not report wages earned on or after the date of injury.
- If reporting weekly earnings, use all 13 Period Columns below. If reporting 3 months of earnings, either convert the wages to weekly earnings or use the first 3 Period Columns. If reporting 14 weeks of biweekly earnings, use the first 7 Period Columns. In all cases, indicate the dates that each period covers.

| PECUNIARY WAGE | INFOR M | ATION | | hourly, we commission commission use of the | ekty, biwee ons. Earnin ons) need to employee's | kly, monthly igs are repo be prorated equipment | r, etc. wage orted in the d. Pecuniary or for payin | s; salary; tip periods the y wages don | es/gratuities; y are earne 't include pa to reimburs | piecework d, NOT wh lyments mai e for travel | compensati en they are de by an em expenses. | on; monetar paid and s ployer to rei Consider as | y allowance: ome (such a mburse the a earnings arr | re not limited to, is, bonuses; and as bonuses and amployee for the bounts from paid not used. |
|---|----------------|-------|--------|--|--|--|--|--|---|---|---|---|---|--|
| PERIOD # (Week #, Month #, or Bi-Week #) | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | |
| FROM DATE: | 3/30 | 4/6 | 4/13 | 4/20 | 4/27 | 5/4 | 5/11 | 5/18 | 5/25 | 6/1 | 6/8 | 6/15 | 6/22 | |
| TO DATE: | 4/5 | 4/12 | 4/19 | 4/26 | 5/3 | 5/10 | 5/17 | 5/24 | 5/31 | 6/7 | 6/14 | 6/21 | 6/28 | TOTALS |
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| Nonpecuniary Employer Specify Value Or Wage Type Provided Prior To Injury? | | | | | ue Or An | | ount Earned in Each Reported Period For Each Benefit Provided Prior To Injury (Use the same periods as used above) | | | | | | Will En Conti | nployer nue To vide? | Date Benefit Suspended (if suspended) | | | |
| | YES | NO | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | YES | NO | 7 |
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| Clothing/ Uniforms | | | | | | | | | | | | | | | | | | |
| Lodging/ Housing/ | | | | | | | | | | | | | | | | | | |
| Food/ Meals | | | | | | | | | | | | | | | | | | |
| Vehicle/ Fuel | | | | | | | | | | | | | | | | | | |
| Other | | | | | | | | | | | | | | | | | | |
| TWCC-3 (Rev. 0) | //04} Pag | e 2 of 2 | | | 1 | | | | | | | | I | TEXA | LS WORKI | ERS' COMI | PENSATI | ON COMMISSION |

TWCC-3 (Rev. 07/04) Page 2 of 2

TEXAS WORKERS' COMPENSATION COMMISSION



4904 Griggs Road Houston, TX 77021 Phone: (713) 676-1460 Fax: (713) 676-1676



то: St. Luke's Hospital From: Karl Guidry

(b) (4)

Fax: 713-784-4499 Pages: 1 Pages to follow

Attn: Rhonda Date: July 2, 2008

See attached documentation regarding our employee Farrier Riley. Be advised Mr. Riley has been released to return to work for a maximum of six hours per day.

Karl Guidry CES Environmental Services, Inc. HSE Manager 4904 Griggs Rd Houston, Texas 777021

****** DATE JUL-02-2008 **** TIME 10:41 *******

DATE/TIME = JUL-02-2008 10:40

JOURNAL No. = 156

COMM. RESULT = OK

PAGE(S) = 002

DURATION = 00:00:23

FILE No. = 304

MODE = MEMORY TRANSMISSION

DESTINATION = 7137844499

RECEIVED ID =

RESOLUTION = STD

-CES Environmental Service-

***** DP-3010 *************** - - ***** - 713 676 1676- *********



4904 Griggs Road Houston, TX 77021 Phone: (713) 676-1460 Fax: (713) 676-1676

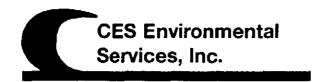


Fax: 1-877-504-4474 Pages: Pages to follow

Attn: Mary Jane Date: July 2, 2008

See attached documentation regarding our employee Farrier Riley. Be advised Mr. Riley has been released to return to work for a maximum of six hours per day. Treating physician's return to work with restrictions are included.

Karl Guidry CES Environmental Services, Inc. HSE Manager 4904 Griggs Rd Houston, Texas 777021



4904 Griggs Road Houston, TX 77021 Phone: (713) 676-1460

Fax: (713) 676-1676



то: Texas Mutual From: Karl Guidry

(b) (4

Fax: 1-512-224-3889 Pages: 1 Pages to follow

Attn: Debbie Garrett Date: June 30, 2008

See attached documentation regarding our employee Farrier Riley. Be advised Mr. Riley has been released to return to work for a maximum of six hours per day.

Karl Guidry CES Environmental Services, Inc. HSE Manager 4904 Griggs Rd Houston, Texas 777021

******* Date JUN-30-2008 **** Time 17:12 *******

Date/Time = JUN-30-2008 17:10

Journal No. = 020

Comm. Result = OK

Page(s) = 002

Duration = 00:00:58

File No. = 602

Mode = Memory Transmission

Destination = 15122243889

Received ID =

Resolution = Fine

-CES ENVIROMENTAL -

***** DP-C264 **************** - - ***** - 7137488664- ********

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| 0.55 of again | Section Successed Planether Found | 4) 7 Com / sonty-Boxto Pisa ph(713)660-9123 | | 10. Eipydiger 8 bijd | ब or Elevat Address (d. His अन्त |
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| history of a work i | related injury | Bellaire | 558⊕ Zin TX 774B1 | | ≓ Eprox Address of Free 1) am |
| ADTIL BIODY | CTATUC DIFOGALATIC | *************************************** | | (512) 224-38 | TION IN 13(c) AS APPLICABLE) |
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| | <u> [</u> | Special studies (list): | | | (date) at : amipo |
| lo / Tanxe el Visit | TEMPLOYEE'S SIGNATURE | None. This is the last I DOCTOR'S SI | | problem. At this time, no Asit Type. Role of D | b further medical care is anticipal Soctor |
| 27/2008 | with the table of district of the | 1 | [1] | L Initial Desi | grintad ductor 💢 Referral do. |
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2008-06-30 10:00

713 475 8688



4904 Griggs Road Houston, TX 77021 Phone: (713) 676-1460 Fax: (713) 676-1676



то: Texas Mutual From: Karl Guidry

(b) (4)

Fax: 1-512-224-3889 Pages: Pages to follow

Attn: Debbie Garrett Date: June 26, 2008

See attached documentation regarding our employee Farrier Riley. Be advised a certified mailing of the bona fide employment offer, the letter signed by Dr. Dent along with the Texas Workers' Compensation Work Status Report has been sent to Mr. Riley.

Karl Guidry CES Environmental Services, Inc. HSE Manager 4904 Griggs Rd Houston, Texas 777021

******** -IND. XMT JOURNAL- ********* DATE JUN-26-2008 ***** TIME 16:11 ********

DATE/TIME = JUN-26-2008 16:09

JOURNAL No. = 054

COMM. RESULT = OK

PAGE(S) = 005

DURATION = 00:00:49

FILE No. = 202

MODE = MEMORY TRANSMISSION

DESTINATION = 15122243889

RECEIVED ID =

RESOLUTION = STD

-CES Environmental Service-

***** DP-3010 ************ - - ***** - 713 676 1676- ********

| CERTIFIED MAIL June 26, 2008 Farrier Riley | Posta Contilled Heturn Receipt F (Endorsement Flequin Restricted Delivery F (Endorsement Requin Total Postage & Fe Sont To Street, Apt. No.; q PO Box No. | 77678 \$0.42 66 \$2.70 68 \$0.00 | 0027 05 Postmar Here | |)PY \6/24/08 G |
|--|---|--|---|----------|------------------------------|
| (b) (4) | r- [3(b) (4) - | | 94, <u>20</u> | silvici. | |
| Dear Farrier Riley, CES Environmental Services, Inc. wassignment at the facility Tank Was! The schedule for this position is 3:00 job pays \$16.00 per hour, which is yrestrictions certified by the emergen whose work status report is attached. The job involves assisting logistics will involve sitting at the work statirequire lifting and is consistent wit! While assigned to this modified—d consistent with your physical ability assignment has been certified by you Bellaire, TX 77401. Training will be | Issue PVI: Total: Paid by: Cash Order stamps at call 1-800-Stam USPS.com/clickn shipping labels other information treating physice e provided as new | SUSPS.com/shop or up24. Go to ship to print with postage. For on call cian, Dr. David Decessary. | \$2.70 4821 ===== \$5.32 ====== \$5.32 nt, 3409 d | | |
| Please contact CES Environmental S Fide Employment Offer, if you are v assignment. If we do not hear from will assume you are no longer intere Environmental Services, Inc. KARL A. GUIDRY CES Environmental Services, Inc. HSE Manager | villing to accept you within 5 day | this temporary, moves of your receipt o | odified job of this notic | ce, we | |
| Accept | | Date | | | |
| Decline | | _Date | | | |

| SENDER: COMPLETE THIS | SECTION | COMPLETE THIS SECTION ON DELIVERY |
|---|---|--|
| Complete items 1, 2, and 3 item 4 if Restricted Delivery Print your name and addreso that we can return the contact and the pactor on the front if space per | y is desired. ss on the reverse card to you. k of the mailplece, | A Signature X |
| Article Addressed to: | | If YES, enter delivery address below: |
| o) (4) | | |
| | | 3. Service Type |
| | | 3. Service Type Griffed Mail |
| | | ☐ Certifled Mail ☐ Express Mail ☐ Registered ☐ Return Receipt for Merchandir |
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| Ferrier Riley | | 1 | dvocate Pain Mane | igament Cente | ar 3 | Ces invironmental | |
| Date of Wyork 5/22/2008 | (b) (4) | | | x(713)660-912 | | L CHEATHAN FALL OF CHARLACTER | Me (d 175mi) |
| Entraloyee's Description o | INNY/ACCIONS | | rvofadilydaca Adressii 109 Bellaire Blyd | Heat address) | | Toxas Mútual Ins | |
| history of a work re | listed injury | Cay | Bellairo | TX 7740: | 1 72 | , Canora Face or Small Address .(512) 224-3888 | (i) Archive) |
| 3. The injured ompi (a) will allow the ∑(b) will allow the through | oyee's medical conditions to restum to employee to restum to projum to by a condition to be and still personals in | nn residii b work of work of | ng from the warkers'd us of (d) of (date | en pensetton inje en pensettier (e in ac strow | rry: <u>Ictions</u> : <u>ctions</u> identi | AND DESCRIPTION OF THE SECTION OF TH | to expected to tool |
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| | RICTIONS (If any); | | 17: MOTION-REST | | | 10. NISC. RESTRICTIO | ME (If ANY): |
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| L HandWisi | C R Hand/Writes | | 18, LIFT/CARRY RI | • | | C Winst Week | |
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12600 N. Featherwood, Suite 200 Houston, Texas 77034-4440 Phone: (713) 223-1234 Fax: (713) 910-9010 Mail@OgletreeAbbott.com

BILL OGLETREE BILL ABBOTT CELINA RECALDE FYODOR CLAY BIANCA MARTINEZ LESUE LEVINGSTON ADRIENNE GASSER ENRIQUE VARELA

TELEFAX COVER SHEET

From Fax Number: (713) 910-9010

If you experience any problems with the quality of our transmission, please call (713) 223-1234

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This fax does not create nor is it intended to create an attorney/client relationship.

PAGES SENT:

, pages including this cover page

TO

Karl A. Guidry, HSE Manager

COMPANY

CES Enviromental

FAX NO

713-676-1676

FROM

Fyodor Clay

DATE

June 26, 2008

RE

Farrier Riley

MESSAGE

We represent the above named employee in connection with his/her Workers' Compensation claim. It has been indicated that the employer might have light duty available. If light, modified or alternative duty is available from the employer, can you provide a Bona Fide Offer of Employment? If yes, pursuant to the Rule 129.6 (c), we request that you provide the Claimant's treating doctor, Dr. David Dent (See attached DWC-73), with a written Bona Fide Offer of Employment.

JUN-26-08 04:00PM FROM- T-810 P.002/004 F-096



12600 N. Featherwood, Suite 200 Houston, Texas 77034-4440 Phone: (713) 223-1234 Fax: (713) 910-9010 Mail@OgletreeLawFirm.com

BILL OGLETREE BILL ABBOTT LISA SECHELSKI CELINA RAMIREZ FYODOR CLAY
LAURA RODRIGUEZ
BIANGA MARTINEZ
JACQUEI YN COLEMAN

June 26, 2008

Attention: Karl A. Guidry, HSE Manager CES Environmental 4904 Griggs Rd. Houston, TX 77021

Re: Our Client:

SSN:

Date of Injury: Claim No.:

DWC No.:

Farrier Riley

May 22, 2008

08272108-MI

Dear Sir or Madam:

We represent the above named employee in connection with his/her Workers' Compensation claim. It has been indicated that the employer might have light duty available. If light, modified or alternative duty is available from the employer, can you provide a Bona Fide Offer of Employment? If yes, pursuant to the Rule 129.6 (c), we request that you provide the Claimant's treating doctor, <u>Dr. David Dent</u> (See attached DWC-73), with a written Bona Fide Offer of Employment.

Per Rule 129.6 (a) of the Texas Administrative Code:

An employer or insurance carrier (carrier) may request the treating doctor provide a Work Status Report by providing the treating doctor a set of functional job descriptions which list modified duty positions which the employer has available for the injured employee (employee) to work. The functional job descriptions must include descriptions of the physical and time requirements of the positions.

Per Rule 129.6 (b) of the Texas Administrative Code:

An employer may offer an employee a modified duty position which has restricted duties which are within the employee's work abilities as determined by the employee's treating doctor. In the absence of a Work Status Report by the treating doctor an offer of employment may be made based on another doctor's assessment of the employee's work status provided that the doctor made the assessment based on an actual physical examination of the employee performed by that doctor and provided that the treating doctor has not indicated disagreement with the restrictions identified by the other doctor.

Per Rule 129.6 (c) of the Texas Administrative Code:

An employer's offer of modified duty shall be made to the employee in writing and in the form and manner prescribed by the Commission. A copy of the Work Status Report on which the offer is being based on shall be included with the offer as well as the following information:

- (1) the location at which the employee will be working
- (2) the schedule the employee will be working;
- (3) the wages the employee will be paid;
- (4) a description of the physical and time requirements that the position will entail; and
- (5) a statement that the employer will only assign tasks consistent with the employee's physical abilities, knowledge, and skills and will provide training if necessary

To reiterate, please forward what the employer purports to be a "Bona Fide Offer of Employment" to the Claimant's treating doctor.

I can be reached via e-mail at <u>Fyodor.Clav@ogletreeabbott.com</u> or via telephone at the number listed above, ext 128. Thank you for your attention to this matter.

EPAHO043000203

****** DATE JUN-26-2008 **** TIME 14:41 *******

DATE/TIME = JUN-26-2008 14:34

JOURNAL No. = 044

COMM. RESULT = OK

PAGE(S) = 026/026

DURATION = 00:06:44

FILE No.

= 192

MODE

= MEMORY TRANSMISSION

DESTINATION = 15122243889

RECEIVED ID =

RESOLUTION = STD

-CES Environmental Service-

***** DP-3010 *************

- ***** - 713 676 1676- *******



4904 Griggs Road Houston, TX 77021 Phone: (713) 676-1460

Fax: (713) 676-1676



то: Texas Mutual From: Karl Guidry

(b) (4)

Fax: 1-512-224-3889 Pages: 25 Pages to follow

Attn: Debbie Garrett Date: June 26, 2008

See attached documentation regarding our employee Farrier Riley. Be advised a certified mailing of the bona fide employment offer signed by Dr. Dent will be sent to Mr. Riley.

Karl Guidry CES Environmental Services, Inc. HSE Manager 4904 Griggs Rd Houston, Texas 777021

******* -IND. XMT JOURNAL- ******** DATE JUN-26-2008 **** TIME 14:41 *******

DATE/TIME = JUN-26-2008 14:34

JOURNAL No. = 044

COMM. RESULT = OK

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DURATION

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FILE No.

= 192

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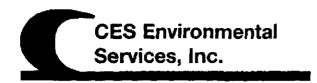
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RESOLUTION = STD

-CES Environmental Service-

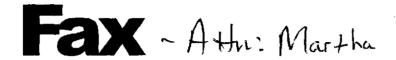
***** DP-3010 *************

- ***** - 713 676 1676- *******



4904 Griggs Road Houston, TX 77021 Phone: (713) 676-1460

Fax: (713) 676-1676



| To: | Texas Mutual | From: | Karl Guidry | | |
|-------|--------------|--------|-----------------|--|--|
| | | | (b) (4) | | |
| Fax: | 713-316-2191 | Pages: | Pages to follow | | |
| Attn: | Workers Comp | Date: | June 4, 2008 | | |

See attached documentation regarding our employee Farrier Riley.

Karl Guidry CES Environmental Services, Inc. HSE Manager 4904 Griggs Rd Houston, Texas 777021

****** Date JUN-09-2008 **** Time 14:30 ******

Date/Time = JUN-09-2008 14:20

Journal No. = 130

Comm. Result = OK

Page(s) = 013

Duration = 00:03:13

File No. = 314

Mode = Memory Transmission

Destination = 7133162191

Received ID = / 7133162191

Resolution = Fine

-CES ENVIROMENTAL

***** DP-C264 ************** - - ***** - 7137488664- ********

Send the specified copies to your Workers' Compensation Insurance Carrier and the injured employee. *Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, CLAIM# Unless the Division specifically requests a direct filling. CARRIER'S CLAIM # EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS 1 Name (Last First Mit 2. Sex _F□ _M□ 15. Date of Injury (m-d-y) 17. Date Lost Time Began 24 D8 4 Home Ohone 5 Date of Right (m-d-v 6. Does the Employee Speak English? If No, Specify Language YES NO T LNCIDENT 7. Race 8. Ethnicity Hispanic 🔲 White [regular job? NO 🔲 Black Asian Native American | Other | 23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site.

1002 N. Kichey, ASA Dewe, 1X 7750

Street or P.O. Box

County 9. Mailing Address Street or P.O. Box City PASA DENC Married Widowed 24. Cause of Injury(fall, tool, machine, etc.) 11. Number of Dependent Children MAChin 29. Dage Reported 26. Return to work 28. Supervisor's date/or expected (m-d-y) (m-d-y) RYAN Zip Code YES NO D 77235 17-08 22. *0*8 30. Date of Hire (m-d-y) 31. Was employee hired or recruited in Texas? 32. Length of Service in Current Position 33. Length of Service in Occupation YES NO I Months 34. Employee Payroll Classification Code 35. Occupation of Injured Worker DRIVER 39. Is employee an Owner, Partner, 37. Full Work Week 38. Last Paycheck was: or Corporate Officer? 1.036fdr 6.2Hours or 40_ Hours 40. Name and Title of Person Completing Form 41. Name of Business NUIRONMENTA 42. Business Mailing Address and Telepho 43. Business Location (If different from mailing Street or P.O. Box-7/3)6 490 a Zip Code Houstoni 7703 **LOUSH**M 77021

51 Signature and title (READ HISTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)

X X A A AMARY HSE MANAGER

Code (6 digit)

45. Primary North American Industry Classification System

YES NO NO

DIVISION OF WORKERS' COMPENSATION

47, Texas Comptroller Taxpayer No.

46. Specific NAICS Code

0001086041

(6 digit)

49. Policy Number

44. Federal Tax Identification Number

EXAS Mutua

<u>/ NO</u> 🗔

48. Workers' Compensation Insurance Company

50. Did you request accident prevention services in past 12 months?

760592985

YES 🗖



| CLAIM# | |
|-----------|--|
| Carrier # | |
| | |

SUPPLEMENTAL REPORT OF INJURY

| Part I EMPLOYER INFORMATION | 1 | | | | | | | |
|---|--|---|---|--|--|--|--|--|
| Employer business name. | 1.1 (22.4) | | 2. Employer phone # | | | | | |
| CES ENVIRONMEN | tal Services | | 713-676-1460 | | | | | |
| 3. Employer mailing address 490 4 Thuas 1 | 1 This Low | TX 77021 | | | | | | |
| 4. Insurance carrier name | U. Tousjery | 1/1 / 1/03-1 | | | | | | |
| TEXAS Mutual | | | | | | | | |
| 5. Does the employer have return to work (| RTW) opportunities available | based on the injured work | er's current capabilities? yes ino | | | | | |
| If so, identify contact person a | nd phone # | | | | | | | |
| 6. Has the insurance carrier provided RTW | coordination services within t | he past 12 months? yes | Dateno | | | | | |
| 7. Has the employer requested RTW training from DWC or the insurance carrier? | | | | | | | | |
| Has the insurance carrier provided accide | 8. Has the insurance carrier provided accident prevention services in the past 12 months? yes Date | | | | | | | |
| Has the employer requested accident pre | vention services from the ins | urance carrier? yes [| no 🔽 | | | | | |
| Part II REASON FOR FILING THIS | REPORT (deadlines | vary, see instruction | s) | | | | | |
| 10. a. The injured worker returned to | o work in either a full or limite | ed capacity: File this report | within 3 days. | | | | | |
| b. The injured worker is earning | more or less than the pre-inj | ury wage because of the in | jury: File within 10 days. | | | | | |
| c. The injured worker returned, | then later had additional lost | time or reduced wages as a | result of the injury: File within 3 days. | | | | | |
| d. The injured worker resigned | | syment: File within 10 days | | | | | | |
| Part III INJURED WORKER INFOR | RMATION | 12. SSN (last 4 district) | 13. DOI | | | | | |
| Frazier Kiley | | xxx-xx | 5-22-08 | | | | | |
| (b) (4) | a.# | | | | | | | |
| wages for this injury (mm/dd/yyyy) | -23-08 | 16. First day or additional or reduced wages (n | | | | | | |
| 17. Has the injured worker experienced 8 da | | _ | of the injury? yes no | | | | | |
| If yes, the date of the 8th day (mm/dd/yyy | N JUNE 1 3K | <u> </u> | | | | | | |
| 18. Date of most recent RTW 5-34-08 | 19. Has the injured worker | resigned, been terminated | or died? yes no | | | | | |
| Full duty, full pay | date of resignation | date of termination | ndate of death | | | | | |
| Limited duty, full pay | 19a. Reason for resignation | /termination | | | | | | |
| Limited duty, reduced pay | 19b. Was the injured worker | r on limited duty when term | inated? yes no | | | | | |
| 20. Hours the injured worker was working du | ring the pay period of | 21. Weekly/hourly earnir | ngs for the pay period of | | | | | |
| 5-12-08 to 6-4-08 | hours per week | to: \$ | weekly or \$ | | | | | |
| Indicated hours are: | | Indicated wages are: | | | | | | |
| Increase from pre-injury | | · ` | om pre-injury wage | | | | | |
| Same as pre-injury | | Same a pr | e-injury wage | | | | | |
| Decrease from pre-injury | | Decrease | from pre-injury wage | | | | | |
| This form to be filed with: The employ | er's insurance carrier and t | he injured worker in the t | imeframe as noted in Part II. | | | | | |
| 22. To the best of my knowledge the inform | ation provided in this report is | accurate and may be relied | d upon for evaluation of eligibility for benefits | | | | | |
| | | | for the employer where injury occurred.) | | | | | |
| VIAL | injured visikel (ii no longer working for the employer where injury occurred.) | | | | | | | |
| Authorn HSA | - MANAGER | lon | 4-08 | | | | | |
| Signature and Title of person completing this for | orm / | Date | | | | | | |
| | | | | | | | | |

DWC FORM-6 (Rev. 10/05) Page 1

DIVISION OF WORKERS' COMPENSATION

Section 1. Please print or type in all information. Please use black ink only. This report must be completed within 24 hours of the Illness/Injury/Incident and forwarded to the Human Resources Department.

| All information reques | ted is required | on the TWCC for | | ith ou | r insurance car | rier. | | |
|--|---|---------------------|----------------------|-------------------------------|--|-------------------------|-------------|---|
| Name of Person Involve | d | | Sex | | cial Security Nur | OOR (A) | | |
| DAVID ESPIA | 024 | | M | | (4) | | - | (b) (4) |
| Marital Status | | | Spause | Spouse's Name (if applicable) | | | | |
| Single Marri | 300036 | 3 19011 | Name (it applicable) | | | Children . | | |
| G Suight Amoni | ed 🗌 Divord | æd | 3 | | | | İ | 1 |
| Home Address | | | | | City | | | State |
| (b) (4) | | | | | | | | |
| | | | | | Sanz | # FE | | TEXAS |
| County of Residence | Phone | | | En | nployee's Occupa | | Facility | 1 7 - 7 - 7 - 7 - 7 - 7 - 7 - 7 - 7 - 7 |
| , | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | \ | | | , , | | 1 | |
| (b) (4) | | | | | ANT OPER | mins | WASH | TURN TURNEL |
| Date of Hire | Experience in | Occupation at Time | of Incident | Da | te of Incident | Time of Incide | | Date Incident |
| (b) (4) | | | , , | ſ | | 22.08 1615 0 | | Reported |
| | 10 | Years 6 | Months | <u> </u> | | | | |
| Employee was working | Emp | loyment Category | | | Phase of Empl | oyee's Workday | at Time of | Injury |
| ☐ Aíone | | Regular, full-time | ☐ Contra | | ☐ Performing | Mark Dution | _ | 7 During Break Contact |
| ☐ With fellow workers | | Regular, part-time | Tempo | | | leaving the Buik | | During Break Period During Meal Period |
| | Other Non-employee | | | ,,, | Other LEAving premise | | | Working Overtime |
| | | | | | | | | |
| Specific Location of Inci | | | | | | _ | | Was it on the |
| ☐ Office | ☐ Eleva | | _ DLab | | = | Press Building | | Employer's Premises? |
| Restroom | | | | | | totion Storage Building | | |
| Parking Area | | | | | | | | Yes 🗌 No |
| │ | | | | | | | | į |
| Photocopy Room | ☐ Tank | | Pond | | | | | |
| ☐ Break Room | | ol Building | Digest | | a AL | TOMATİL FI GAR | RENT | |
| Stairs | | enance Area | Lay D | own Ya | ard | 6AR | 5 | |
| Severity | | | Dist | ositio | n | | | Sent to: |
| No apparent Injury | ☐ Mandi | ani Trant-mont | | 3040 o | way from work # | | 4 | ☐ Hospital |
| No apparent Injury ☐ Medical Treatment ☐ First Aid ☐ Fatality | | | | | way from work # ted work days # turned to work | 1 | □ ⊓ospitai | |
| Lost Work Days Other | | | | | sturned to work | | ☐ Doctor | |
| | | | | | | | | |
| Name and Address of Treating Physician Name and Address of Hospital | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | · · · · · · · · · · · · · · · · · · · |
| } | | | | | | | | |
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| 0, | | | | <u> </u> | 11 | | | ! |
| Phone # | | | | Phone # | | | | |
| <u> </u> | | | | 1 | | | | |
| Describe the accident. | What happened | d? Include what you | n wede dojuć |) befor | e the accident. (I | f additional spac | ce is neede | d, altach separale sheef |
| of paper) Please print i | neatly. CES 7 | TRANSPORT TRUC | R DINE | te A | lsking for . D | ikecTións - : | ut Av70 | - PRINT GATE - OPEN WAS UPON him - |
| THERMED Drivek | . GATE WAS | Closing - wait | cin my D | KKW | . he told | me to so wh | EN GATE | was upon him - |
| Ac To sulled as a | يام صلاي | shed Gate A. | ا کے سم | K.>_ | A officer of | سده سمرم ملاء | 4.4. | المريوسية أأسمم مثا |
| LO T brings and | ر الم | and jule A | אין עד | | THERE Y | PAIC CHRUSH | TTOIR ! | TO POUT POCKET |
| get stopped aff | ander " | hen I get ei | .T 04 M | yπ | ucic ~ horea | NIM IT IN | r mas c | Finy he said yes |
| PIRCOT CIL TORA | pants · N | unit sciented o | n ho mr | * • • | WEST NICH | INCh Tried | 40 m | Sale Breic on Fraci |
| ment in with thirt operature - CHETTETE SEMICE . HE INTORMED THE to go on home - that he would take | | | | | | | | |
| Interned Driver. Gate was closing while in my pickup. he told me to go when gate was upon him - As. I publish among he pushed gate Away from him + truck- gate congret tore his poot pocket gate shopped aff track when I get out of my truck- Asked him if he was ciking he said yes except for torn pants minist scotch on his man what raken than tried to put gate brick on track met up with chief operator - CHETTEN Semien - He informed me to go on home - that he would take LAKE of Situation - 25 SATO ARE YOU SURE - He said - yes - Go - Home and So I DOD - | | | | | | | | |
| Body Part Affected (Be very specific): Equipment or Property Damaged? What could you have done to prevent this | | | | | | | | |
| accident? MeVED RUKTHERL PROM | | | | | | | | |
| (| | 🗋 Yes | □ No If | yes, P | lease Describe: | | | |
| į | (| | _ | • | OF TRACK | | SATE. | ALCENT, |
| <u> </u> | LL | | BAIL | | WITT I POST | | | |
| | 1. 1 | 7 // | 1 | | | Date 5 · 26 | - AP | |
| Employee's Signature _ | (And | & Depurera | - | | | Date <u>3 · 24</u> | , UA | |
| } | , | | 1 | | | | | |
| 1 | L | | | | | | | |

GCA Accident and Near Miss Report

Confidential Report, page 2

| Witness Statement (if applicable) If more than one witness, attach a separ | rate sheet. |
|--|---|
| Witness Signature and Date | Phone # |
| Section 2.—To be completed by Supervisor/Manager or Safety Coord Supervisor's Description of Incident. — DAS NOT WITHESS, **THIS IS NOT THE FIRST ACCIDENT STRADIUM — THE GATE THAT SHAD **IDO NOT STOP - GATE CLOSES A Supervisor's Name and Signature and Date **Y New 5. | TO OCCUR BETAUSE OF VEHICLES OLD, CONSTRER POSITION SIGNS HUTOMATICALLY! |
| Supervisor's Name and Signature and Date // What conditions of Foots Equipment of Work A Contributed to the Incident | Witnessed Incident? Yes No Whatcausedion ribshced substandard Conditions No Applicable Abuse or Misuse Improper Work Surfaces Inadequate Maintenance Inadequate Guards/Barriers Lack of Knowledge/Training Defective Tools/Equipt/ehicle Inadequate Supervision Illumination Inadequate Tools/Equip/Mat. Inadequate/Improper PPE Inferior Equipment |
| What action or inaction contributed to the Incidents. Second Description Description Used Equipment Improperly Operating Procedure Deviation Improper Loading Servicing/Operating Equipment Improper Technique Running/Rushing/Acting in Haste Failure to Warn/Signal Used Wrong Tool/Equipment Used Defective Equipment Inadequate/Improper PPE Use Improper Lifting Operating at Improper Speed Unauthorized Actions Nullified Safety/Control Devices Improper Position None Horseplay/Distractive Action Other | Improve Enforcement |
| Specific Corrective Actions or Preventative Measures Taken Corrective Action Taken Person R | Responsible Target Date Completed |
| Supervisor' Signature My N. Ley Safety Coordinator Signature Mulul E S/27/08 | Manager's Signature See 27-09 Received in HR by Date |

I pulled up to sate went to front Office it was locked noone was inside. As I was about to get into truck someone was pulling out of plan. - Stood outside of truck to ask if I was at the right place as me and the guy who stop to and help were looking at my paper work. The gate begain to close before I could react I was in between the gate and the truck as the truck pulled away the gate pushed me into the truck and I rolled off the truck with gate in hand and when it slipped off track that's when it stopped. The gate made cuts and tore off clothes.

1625

Favois Riley

Refuse medical care from Dr. or Hospital, Cleanes cut on left rist, small cut on right arm cleaned and did medical treatment, some brushing on right side of Chest, under breat area.

Cheste & Semien Favoier Riley Witness Clark Wage

1710 - Driver Came back said he do wont to go to hospital, get X-rays of Chest.

Che



Claim & Information Services P.O. Box 12029 Austin, TX 78711-2029

(512) 224-3800 1-800-859-5995

Fax (512) 224-3889

June 20, 2008

Re:

C E S ENVIRONMENTAL SERVI 4904 GRIGGS RD HOUSTON, TX 77021-3208

Claim #:

Employee: Soc. Sec.: C E S ENVIRONMENTAL SERVI Employer:

FARRIER RILEY

Date of Injury: 05/22/2008

DWC#:

In accordance with the Division of Workers' Compensation Rules, we are requesting that you submit the information indicated below. The DWC3 and DWC6 forms are available for printing from our website, www.texasmutual.com, under services, or from the division's website, www.tdi.state.tx.us. For your convenience, a DWC3 is now available for you to complete and submit on-line. It is located on our website, www.texasmutual.com under the Employers - Loss Run & Claims Detail Section. If you need assistance with filing the DWC3 on-line please contact me. If you do not have access to the Internet, we will be happy to send you a blank form.

| ⊠ OR | DWC3 EMPLOYER'S WAGE STATEMENT (Rule 128.2) - Please fax or email attachment or use the on-line version (www.texasmutual.com). |
|-------------|--|
| | DWC3SD EMPLOYER'S WAGE STATEMENT FOR SCHOOL DISTRICTS (Rule 128.7) |
| \boxtimes | DWC6 EMPLOYER'S SUPPLEMENTAL REPORT OF INJURY OR ILLNESS (Rule 120.3) - Please fax or email attachment. The following time frames apply. |
| | Within 10 days after: |
| | The end of each pay period in which the employee's earnings have changed as a result of the injury, OR The employee resigns or is terminated. |
| | Within 3 days after: |
| | The employee begins to lose time from work as a result of the injury, OR The employee returns to work, OR |
| | • The employee, after returning to work experiences an additional days(s) of disability as a result of the injury. |
| | p provide the required information is an administrative violation and may result in the assessment of a penalty from the Division of Compensation. |
| | EMPLOYEE ACKNOWLEDGEMENT OF WORKERS' COMPENSATION NETWORK FORM (This form(s) shall be completed, signed and submitted). Please fax or send attachment via email as soon as possible. |
| | COPY OF THE POST-ACCIDENT DRUG SCREEN RESULTS |
| Thank yo | ou for your prompt attention to this matter. If you have any questions, please call me at 1-800-859-5995 ext. 2243. |
| Sincerely | / , |

Debbie K Garrett WORKERS' COMPENSATION SPEC II

Employee Acknowledgment of Workers' Compensation Network

I have received information that tells me how to get health care under my employer's workers' compensation insurance.

If I am hurt on the job and live in a service area described in this information, Lunderstand that:

- 1. I must choose a treating doctor from the list of doctors in the network. Or, I may ask my HMO primary care physician to agree to serve as my treating doctor. If I select my HMO primary care physician as my treating doctor, I will call Texas Mutual at (800) 859-5995, extension 2880 to notify them of my choice.
- 2. I must go to my treating doctor for all health care for my injury. If I need a specialist, my treating doctor will refer me. If I need emergency care, I may go anywhere.
- 3. The insurance carrier will pay the treating doctor and other network providers.
- 4. I might have to pay the bill if I get health care from someone other than a network doctor without network approval.
- 5. Making a false or fraudulent workers' compensation claim is a crime that may result in

| Torries hivey Signature Horizon Pare Historian Historian Historian Pare Hi |
|--|
| Farrier Riley |
| I live at: Street Address |
| (b) (4) City State Zip Code |
| Name of Employer: CES ENVIronmental Services, Inc. |
| Name of Network: Texas Star NetworksM |
| Network service areas are subject to change. Call (800) 381-8067 if you need a network treating provider. |
| Please indicate whether this is the: |
| Initial Employee Notification |
| Injury Notification (Date of Injury: //) |

DO NOT RETURN THIS FORM TO TEXAS MUTUAL INSURANCE COMPANY UNLESS REQUESTED

Employee Notice of Network Requirements - 03/06

Page 8 of 8

| Send to worke | rs' compensation carrier: | |
|---------------|------------------------------|--|
| (nam | e and fax number of carrier) | |



| TWCC# |
|------------------|
| CARRIER'S CLAIM# |

| Г | Initial | Amended |
|---|---------|---------|
| ш | minai | Amended |

EMPLOYER'S WAGE STATEMENT

The Texas Workers' Compensation Act and Commission rules require an employer to provide an Employer's Wage Statement to its workers' compensation insurance carrier (carrier) and the claimant or the claimant's representative, if any. The purpose of the form is to provide the employee's wage information to the carrier for calculating the employee's Average Weekly Wage (AWW) to establish benefits due to the employee or a beneficiary.

The AWW is based on the wages the employee earned in the 13 weeks immediately preceding the date of injury (or the wage a similar employee earned if the employee did not work the full 13-week period). "Wages" include all forms of remuneration payable to an employee for personal services, including fringe benefits. To simplify filling, employers may file wages in a monthly, biweekly, or weekly manner as discussed below.

NOTE - An employer who fails without good cause to timely file a complete wage statement as required by the Texas Workers' Compensation Act, Texas Labor Code, Section 408.063(c) and Commission Rule 120.4 may be assessed an administrative penalty not to exceed \$500.00 for an initial offense and not to exceed \$10,000.00 for a repeated administrative violation.

The employer shall timely file a complete wage statement in the form and manner prescribed by the Commission.

- (1) The wage statement shall be filed ("filed" means received) with the carrier, the claimant, and the claimant's representative (if any) within 30 days of the earliest of:
 - (A) the employee's eighth day of disability;
 - (B) the date the employer is notified that the employee is entitled to income benefits;
 - (C) the date of the employee's death as a result of a compensable injury.
- (2) The wage statement shall also be filed with the Commission within seven days of receiving a request from the Commission (Only When Requested).
- (3) A subsequent wage statement shall be filed with the carrier, employee, and the employee's representative (if any) within seven days if any information contained on the previous wage statement changes (such as if the employer discontinues providing a nonpecuniary wage that was initially continued after the date of injury).

All applicable TWCC rules can be found at www.twcc.state.tx.us

| EMPLOYEE AND EMPLOYER INFORMATI | ON | | | |
|--|------------------------|--|---|--|
| Employee's Name (Last, First, M.L): | | Employer's Business Nam | | |
| Riley Farrier D. | | CES Environ | mental | Services Anc |
| Employee's Mailing Address (Street or P.O. Box): | | Employer's Mailing Addres | s (Street or P.O. B | Box): |
| (b) (4) | | 4904 Griggs | RR | |
| City: State: ZIP Code | <u>a:</u> | City: | State: | ZIP Code: |
| (b) (4) | | 4 JOLESTON | X | 77021 |
| Social Security Number: | | Federal Tax I D. Number: | | |
| (0) (4) | | 16-059298 | | |
| Date of Hire: Date of Injury: | | Name and Phone # of Per | son Providing Wag | e Information: |
| (b) (4) | | | | |
| As of today's date, the employee is not back at world | k. OR | I HEREBY CERTIFY THA | T this wage stater | ment is complete, accurate, and |
| The employee returned to work on | | | | sation Act and applicable rules, |
| without restriction, OR | ļ | | | nd nonpecuniary wages paid for |
| with restrictions and is earning wages of \$ | per | | | injury (as described on page 2) |
| week/month (circle one). | , | | | presentation about a workers' tin fines and/or imprisonment. |
| NOTE - Rule 120.3 requires the employer file the Suppler | mental Report of | oomponoutan damin is a di | inic that our regar | titi iines anaisi iinprooriiinem. |
| Injury (TWCC-6) to report changes in Work Status and Post-li | njury Earnings. | Signature: | · — — · · · · · · · · · · · · · · · · · | Date: |
| EMPLOYMENT STATUS AT TIME OF INJU | RY (Check A | il That Apply) | | |
| Full-time: employee who regularly works at Pa | art-time; Regular | r Course of Conduct: | Minor: emp | loyee less than 18 years of age |
| least 30 hours per week and whose schedule is employ | yee whose work | history for the 12-month | and not emand | lpated by marriage or judicial |
| | | iry shows the person anly | | also an apprentice, trainee or |
| | d part-time during the | nat period. ular Course of Conduct: | student. | molecuse complied in a course of |
| employ | | history for the 12-month | | inployee enrolled in a course of nool, college or other institute of |
| Seasonal: employee who as regular course of period | | ry shows part-time and full | | or technical training. |
| conduct engages in seasonal or cyclical time w | ork during that peri | iod. | | J |
| | | e who is learning a skilled | | nployee undergoing systematic |
| vear | | al experience under the | | practice in some art, trade or |
| direction | on of a skilled craft | s person or artisan. | profession with a | view towards proficiency in it. |
| SAME OR SIMILAR EMPLOYEE? | | If the employee was not s | employed for 13 co | intinuous weeks before the date |
| The wage information on this form is for: | | | | who has training, experience, |
| | (NOTE IF | | | employee AND who performs |
| The Injured Employee OR A Similar Employ requested by the Commission, the employer shall ide | ee (NOIE - It | | | number of hours. If no similar |
| employee whose wages were provided.) | inary inic antiliar | i employee exists, repor | | allable wages earned by the |

NOTE TO INJURED EMPLOYEE - If you were injured on or after 7/1/02, and had employment with more than one employer on the date of injury, you can provide your insurance carrier with wage information from your other employment for the carrier to include in your AWW and this may affect your benefits. Contact your carrier for additional information or call the Commission at (800) 252-7031. You can also read rule 122.5 at www.twcc.state.tx.us.

TWCC-3 (Rev. 07/04) Page 1 of 2

TEXAS WORKERS' COMPENSATION COMMISSION

| WAGE INF | ORMA | INOIT | NSTR | JCTION | S | R | Yeu. | Fai | rrier | | (b | (4) | | | | Ŭ. | ate of frijus | , |
|--|-------------------------------------|------------------------------------|----------------------------------|----------------------------------|---|---------------------------------------|---|---|--|--|--|--|---|---|--|--|---|--|
| employer may 4.34821. If th | y provide ne emplo v adjust t | wages yee is p he repor | for the aid on a ting peri | 3 months biweekly od backw | preceding basis, the ard slightly | weeks of g the dat employe | mmedia e of inju er may p | ately pro ury. Moi provide t | eceding othly was he wage: | es may a for the | of injury. also be co 14 weeks p | н инстентической п preceding | weekly | wages of injur | by divid y. Whe | ding the gr in setting th | oss mont ne period | othly basis, the thly amount by s to report, the imployer shall |
| - If reporting w reporting 14 w | | | | | | | | | | | | | | | nings or | use the fir | st 3 Perio | od Columns. If |
| PECUNIAR | Y WA | GE INF | ORMA | TION | | hourty, commis commis use of | weekly. ssions. I ssions) na the empla | biweekly, Earnings ead to be byee's eq | manthly, are report prorated, uipment o | etc. wage ted in the Pecuniary ir for payin | s; salary; tip periods the wages don g helpers or | ss/gratuitles y are eam 't include p to reimbur | i; piecew ed, NOT ayments se for tre | ork <i>co</i> m; when th made by well expe | pensation ley are p an empli nses. Co | i; monetary vaid and sor oyer to reimi | allowance ne (such a purse the d amings an | re not limited to: s; bonuses; and as bonuses and amployee for the nounts from paid not used. |
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4904 Griggs Road Houston, TX 77021 Phone: (713) 676-1460

Fax:

(7.13) 676-1676



Texas Mutual Karl Guidry To: From:

1-512-224-3889 Fax: 1 Pages to follow Pages:

Debbie Garrett July 2, 2008 Attn: Date:

See attached documentation regarding our employee Farrier Riley. Be advised Mr. Riley has been released to return to work with no restrictions.

Karl Guidry CES Environmental Services, Inc. **HSE Manager** 4904 Griggs Rd Houston, Texas 777021

713-676-1460 Ext 115 713-676-1676 Fax kguidry@cesenvironmental.com ******* -IND. XMT JOURNAL- ******** DATE JUL-02-2008 **** TIME 15:05 *****

DATE/TIME = JUL-02-2008 15:03

JOURNAL No. = 174

COMM. RESULT = OK

PAGE(S)

= 006

DURATION = 00:01:39

FILE No.

= 322

MODE

= MEMORY TRANSMISSION

DESTINATION = 15122243889

RECEIVED ID =

RESOLUTION = STD

-CES Environmental Service-

***** DP-3010 ***************

- ***** - 713 676 1676- ******



CERTIFIED MAIL RETURN RECEIPT REQUESTED

| June 26, 2008 | |
|---------------|--|
| Farrier Riley | |

| Farrier Riley (b) (4) | |
|--|--|
| assignment at the facility Tank W The schedule for this position is 3 job pays (b) (4) rer hour, which i | would like to offer you a temporary, modified job duty ash area, located at 4904 Griggs Rd in Houston, Texas. 3:00 pm to 11:00 pm Monday through Friday, and the s your current rate of pay. The job duties meet the work ency room physician at St. Luke's Episcopal Hospital, ned. |
| | es with coordination of transport vehicles. Your duties ation and walking the facility yard. This job will not ith the physician limitations. |
| consistent with your physical abil | duty job position we will only assign tasks that are ities, knowledge and skills. This modified-duty job your treating physician, Dr. David Dent, 5409 Bellaire, ll be provided as necessary. |
| Fide Employment Offer, if you ar assignment. If we do not hear fro | al Services, Inc within 5 days of receipt of this Bona re willing to accept this temporary, modified job om you within 5 days of your receipt of this notice, we erested in continuing your employment with CES |
| Accept 4 avill Ril | Date 7-2-08 |
| Decline | Date |

| Clast Lake Degional Medical Con- | · · · · · · · · · · · · · · · · · · · | Patient Infor | mation | Treating Provider | Discharge Summary | | |
|--|--|----------------|--|---|-------------------|--|--|
| Clear Lake Regional Medical Cerr Clear Lake Regional - Pearland Eme 10970 Shadow Creek Ranch Parkwa 77584 | rgency | riley, farrier | | Bobby Chu MD 10970 Shadow Creek Ranch Parkway Pearland, TX 77584 Phone: 713-770-7200 | Patient Copy | | |
| 1) Your Discharge Instruction | s: | | 2) Your Pr | escriptions: | | | |
| CHRONIC BACK PAIN #Document: 32 BACK EXERCISES #Document: 32 NARCOTIC MEDICATION #Docum | (English) | | 2) Your Prescriptions: Prednisone Oral Tablet 50 Milligram 1 TABLET DAILY # 4 TABLETS (0 Refills) Norco Oral Tablet 7.5-325 Milligram 1 TABLET EVERY 4 TO 6 HOURS AS NEEDED # 15 TABLETS (0 Refills) Valium Oral Tablet 5 Milligram 1 TABLET 3 TIMES DAILY # 6 TABLETS (0 Refills) | | | | |
| 3) You should Follow Up with: | | | | | | | |
| Follow Up Physician: | Follow Up Inforn | | 1 | M | | | |
| YOUR REGULAR PHYSICIAN, | On 07/1/2008 this patient was treated in the Emergency Department at Clear Lake Regional - Pearland Emergency located at 10970 Shadow Creek Ranch Parkway Pearland, TX 77584 for Refer to Discharge list above. The patient was asked to follow up 2 Days. | | | | | | |
| Phone: Fax; | . | | | | | | |

I understand that the emergency care which I received is not intended to be complete and definitive medical care and treatment. I acknowledge that I have been instructed to contact the above physician immediately for continued and complete medical diagnosis, care and treatment. EKG's, X-rays, and lab studies will be reviewed by appropriate specialists and I will be notified of significant discrepancies.

I also understand that my signature authorizes this Medical Center to release all or any part of my medical record (including, if applicable, information pertaining to AIDS and/or HIV testing, mental health records, and drug and/or alcohol treatment) to the referred physician listed above.

| Clear Lake Regional Medical Center | Patient Information | Treating Provider | Discharge Instructions |
|--|--------------------------|--|------------------------|
| Clear Lake Regional - Pearland Emergency 10970 Shadow Creek Ranch Parkway Pearland, TX 77584 | riley, farrier Phone: | Bobby Chu MD 10970 Shadow Creek Ranch Parkway Pearland, TX 77584 | Patient Copy |
| 10070 GROUGH GICCA MAININ AINHAY FEBRUARI, 12 11304 | | Phone: 713-770-7200 | Page: 1 of 1 |

| D-4:4 | D: | Instructions | |
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| L 02510116 | Distributed | III GU UÇUÇU I | |

Document: 77

CHRONIC BACK PAIN

A small number of patients with back injuries have pain that lasts longer than 3 months. A ruptured disc can cause chronic back pain, but half of the time the exact cause cannot be found, even after x-rays and other tests have been done. Arthritis, osteoporosis, tumors, infections, previous back surgery, and other causes may be involved. Anxiety and depression are common factors. A ruptured disc often causes sciatica, a pain traveling from the low back down the back of the leg. This is due to irritation of the sciatic nerve. Surgery is considered only when symptoms do not improve with bed rest and other conservative treatment.

Follow These Instructions Carefully:

- 1. You should avoid bending, heavy lifting, prolonged sitting, and activities, which make the problem worse.
- 2. Try to continue with normal activity as much as possible, taking brief periods of rest throughout the day to reduce your pain during bad periods. A back exercise rehabilitation program can be very helpful in reducing symptoms and preventing further episodes of pain.
- 3. Aspirin, ibuprofen, and other anti-inflammatory pain medicine can help control pain, and muscle relaxants are sometimes used.
- 4. Rest and relax your back muscles. Try to find a position of comfort. Lie flat on your back on a firm surface with pillows under your knees; or lie on your side with your knees bent up towards your chest and a pillow between your knees. (If your mattress sags, place a piece of plywood under it or lie on a floor pad for more support.)
 - For severe back pain stay in this position until you are feeling better. Get up only to go to the bathroom or for meals.
 - For less severe back pain, strict bed rest is not needed. However, don't do anything that worsens the pain and avoid prolonged sitting. Be aware of safe bending and lifting methods. Do not lift anything over 15 pounds until all pain is gone.
- 6. <u>Ice packs</u> (crushed or cubed ice in a plastic bag, wrapped in a towel) are best for 20 minutes every 2-4 hours during the first two days after a new injury. <u>Local heat</u> (hot shower, hot bath or heating pad) and <u>massage</u> will help reduce muscle spasm. You can start with ice packs then switch to heat after two days. Some patients feel best alternating treatments. Use the method that feels best to you for.

Follow up with your doctor or this facility if your symptoms do not start to improve after one week. Physical therapy may be needed.

(NOTE: If X-rays were taken, a radiologist will review them. You will be notified of any new findings that may affect your care.)

Return to this facility immediately or contact your doctor if you begin to have any of the following:

- Pain becomes worse.
- Marked weakness or numbness in one of your legs.
- You have trouble controlling your bladder or bowels.

Discharge Instructions Special Notes

I understand that the emergency care which I received is not intended to be complete and definitive medical care and treatment. EKG"s, X-rays, and lab studies will be reviewed by appropriate specialists and I will be notified of significant discrepancies.

| Cionel aka Dagional Modical Contar | Patient Information | Treating Provider | Discharge Instructions |
|---|---------------------|--|--------------------------------|
| Clear Lake Regional Medical Center | iley, famer | Bobby Chu MD | Date: 7/1/08 Time: 11:54:11 AM |
| | | 10970 Shadow Creek Ranch Parkway Pearland, TX 77584 | Patient Copy |
| Clear Lake Regional - Pearland Emergency | Phone: | Paikway Featiano, 12 77504 | i alicin copy |
| 10970 Shadow Creek Ranch Parkway Pearland, TX 77584 | 1 | Phone: 713-770-7200 |] |
| | | | Page: 1 of 1 |

Patient Discharge Instructions

Document: 548

NARCOTIC MEDICATIONS

You have been prescribed narcotic. Narcotic medicines are used to relieve pain. Some examples of narcotic medicines include the following:

- Codeine (Tylenol #2, #3 cough syrup)
- Propoxyphene (Darvocet, Darvon)
- Hydrocodone (Vicodin)
- Oxycodone (Percocet, Percodan)

This drug may cause drowsiness. Therefore, be sure to take it only as directed.

How To Take This Medication:

- 1. If this medicine makes your stomach upset, take it with food.
- 2. Pain medicine should be taken only if needed at the times prescribed. If you are not having pain, do not take the medicine, unless you are advised to do so by your doctor.
- 3. Narcotic medicines can be habit forming; therefore, take this medicine only as directed. **Do not take** more of it, **do not take** it more often, and **do not take** it for a longer period of time than directed.

What You Should Watch Out For:

Possible Side Effects:

- If you have dizziness, or drowsiness, take a smaller dose, breaking a pill in half or take it less often.
- If you develop constipation, drink lots of liquids, use small doses of a mild laxative like Milk of Magnesia as needed and add fiber to your diet.
 - If you have difficulty passing urine, stop taking the medicine and contact your doctor.

Possible Allergic Reactions: Rash, itching, swelling, trouble breathing or swallowing. You should contact your doctor or return to this facility immediately.

Medical Conditions: Before you begin to take this medicine, be sure your doctor knows if you have any of the following conditions:

- Prostate enlargement.
- Pregnancy or breast-feeding.

Possible Drug Interactions: This drug may cause increased side effects when taken with alcohol, muscle relaxant, sedative, tricyclic antidepressants, MAO-inhibitor or another pain medicine. Make sure your doctor knows what other medicines you are taking.

Note These Warnings:

- Do not drive, ride a bicycle, operate dangerous equipment, climb a ladder or do any other activity where you must concentrate and might
 be injured for at least 12 hours after taking this medicine until you know how it will affect you.
- Prolonged use of this medicine can be habit forming and may lead to addiction.
- Tell your doctor what other medicines you are taking.
- Do not drink any alcohol while taking this medicine.

Stop taking this medication and call your doctor or return to this facility right away if you notice any of these problems:

- Hives or itching.
- Confusion, dizziness, or lightheadedness.
- Hallucinations.
- Blurry vision.
- Slow breathing, slow heartbeat, or severe weakness.
- Nausea or vomiting.
- Stomach pain or chest pain.
- Anything else that worries you.

Discharge Instructions Special Notes

I understand that the emergency care which I received is not intended to be complete and definitive medical care and treatment. EKG"s, X-rays, and lab studies will be reviewed by appropriate specialists and I will be notified of significant discrepancies.

Copyright ScriptRx, Inc. 2000-2005

http://www.ScriptRx.com

| Clear Lake Regional Medical Center | Patient Information | Treating Provider | Discharge Instruction |
|--|---|---------------------------------------|--------------------------------|
| Clear Lake Regional - Pearland Emergency 10970 Shadow Creek Ranch Parkway Pearland, TX 77584 | 10970 Shadow Creek Ranch Parkway Pearland, TX 77584 Phone: 713-770-7200 | Patient Copy | |
| Patient Discharge Instructions | | Document: 4 | 49 |
| | Work Release Form | | |
| This notice verifies that your employee, was seen in this facility on He/sh | ile Deco | yne, Rilei by 68 with the followin | ng restrictions: |
| None: | \ | , | · |
| | • | pounds) | |
| No pro | olonged standing: | | |
| Desk | Work Only: | | |
| Other | : | | |
| Restrictions: | | | |
| | | | |
| These restrictions apply through After the | his date, your employee should | be able to participate fully in a | ll work duties. |
| NOTE: If symptoms continue and the employee is unab this facility or make an appointment with the referral phy | le to perform the full duties of the solution for further evaluation. | neir job by this date, please adv | rise the employee to return to |
| DR. Chy KBW Attending MD | | | |
| Discharge Instructions Special Notes | | | |
| E 30 mondonono operiar notes | | | |

I understand that the emergency care which I received is not intended to be complete and definitive medical care and treatment. EKG"s, X-rays, and lab studies will be reviewed by appropriate specialists and I will be notified of significant discrepancies.



CERTIFIED MAIL RETURN RECEIPT REQUESTED

June 24, 2008

To:

Dr. David Dent (b) (4)

From: Karl Guidry

CES Environmental Services, Inc.

4904 Origgs Rd.

Houston, Texas 77021

Re: Workers Comp Claim for Farrier Riley

TEXAS MUTUAL CLAIM

Dear Dr. Dent,

CES Environmental Services, Inc. would like to offer your patient, Farrier Riley a temporary, modified job duty assignment at the CES Environmental Services, Inc facility, located at 4904 Griggs Rd in Houston, Texas. This modified duty position meets the requirements of Rule 129.6 (a) of the Texas Administrative Code.

The schedule for this position is 3:00 pm to 11:00 pm Monday through Friday, and the job pays per hour, which is his current rate of pay. Please determine if the job duties describe below meet the work restrictions which you are willing to certify. Please be advised that as of this date we have received no indication of return to work recommendations from your office nor have we received any work status documentation from you regarding Farrier Riley.

The job involves assisting logistics with coordination of transport vehicles. Mr. Riley's duties will involve sitting at the work station and walking the facility yard to coordinate parking of tankers and rolling stock. This job will not require lifting or driving and we believe is consistent with any treating physician limitations.

While assigned to this modified duty job position we will only assign tasks that are consistent with Mr. Riley's physical abilities, knowledge and skills. Training will be provided as necessary.

Please indicate if you are willing to certify this temporary, modified job assignment for Farrier Riley.

| I Certify (Sign) | Date 6/25/38 | _ |
|-------------------------|--------------|---|
| I do not Certify (Sign) | Date | _ |

Regards,

Karl A. Guidry

CES Environmental Services, Inc.

HSE Manager 4940 Griggs Rd.

Houston, Texas 77021



12600 N. Featherwood, Suite 200 Houston, Texas 77034-4440 Phone: (713) 223-1234 Fax: (713) 910-9010 Mail@OgletreeAbbott.com

BILL OGLETREE BILL ABBOTT CELINA RECALOS FYODOR CLAY BIANCA MARTINEZ LESLIE LEWINGSTON ADRIENNE GASSER ENRIQUE VARELA

TELEFAX COVER SHEET

From Fax Number: (713) 910-9010

If you experience any problems with the quality of our transmission, please call (713) 223-1234

CONFIDENTIALITY NOTICE

This fax and any attachments are confidential and may be protected by legal privilege. If you are not the intended recipient, be aware that any disclosure, copying, distribution or use of this fax or any attachment is prohibited. In such case, you should destroy this fax and kindly notify the sender. Please advise immediately if you or your employer do not consent to faxes of this kind. Opinions, conclusions and other information in this fax that does not relate to the official business of my firm shall be understood as neither given nor endorsed by it.

This fax does not create nor is it intended to create an attorney/client relationship.

PAGES SENT:

, pages including this cover page

TO

Karl A. Guidry, HSE Manager

COMPANY

CES Environmental

FAX NO

713-676-1676

FROM

Fyodor Clay

DATE

June 22, 2008

RE

Farrier Riley

MESSAGE

We represent the above named employee in connection with his Workers' Compensation claim. I am in receipt of what the employer purports to be a "Bona Fide Offer of

Employment." (See Exhibit A). After careful review it has come to my attention that it does not meet the requirements set forth in Rule 129.6 of the Texas Administrative Code,

therefore rending it invalid.

BILL OGLETREE

LISA SECHELSKI

CELINA RAMIREZ

BILL ABBOTT

12600 N. Featherwood, Suite 200 Houston, Texas 77034-4440 Phone: (713) 223-1234 Fax: (713) 910-9010



Mail@OgletreeLawFirpt.com

FYODOR CLAY
LAURA ROBRIGUEZ

FYODOR CLAY LAURA RODRIGUEZ BIANCA MARTINEZ JACQUELYN COLEMAN

June 22, 2008

CES Environmental

Attention: Yvonne L. Medelez

4904 Griggs Rd. Houston, TX 77021

Re:

Our Client:

SSN:

Date of Injury:

Claim No.: DWC No.: Farrier Rilev b) (4)

May 22, 2008

08272108-MI

Dear Sir or Madam:

We represent the above named employee in connection with his Workers' Compensation claim. I am in receipt of what the employer purports to be a "Bona Fide Offer of Employment." (See Exhibit A). After careful review it has come to my attention that it does not meet the requirements set forth in Rule 129.6 of the Texas Administrative Code, therefore rending it invalid.

An employer may offer an employee a modified duty position, which has restricted duties which are within the employee's work abilities as determined by the employee's <u>treating doctor</u>. In the <u>absence</u> of a Work Status Report by the treating doctor an offer of employment may be made based on another doctor's assessment of the employee's work status provided that the treating doctor has not indicated disagreement with the restrictions identified by the other doctor. To the best of my knowledge, the Claimant's treating doctor has the clamant off work. It is the Claimant's treating doctor who determines work restrictions. APPEAL 061195 – JULY 28, 2006.

According to Rule 129.6(b), it is only in the absence of a DWC-73 by the treating doctor that an offer of work may be made based on another doctor's DWC-73. A further restriction is that the treating doctor has not indicated disagreement with the other doctor's restrictions. APPEAL 071650 - NOVEMBER 12, 2007.

Per Rule 129.6 (a) of the Texas Administrative Code:

(a) An employer or insurance carrier (carrier) may request the treating doctor provide a Work Status Report by providing the treating doctor a set of functional job descriptions which list modified duty positions which the employer has available for the injured employee (employee) to work. The functional job descriptions must include descriptions of the physical and time requirements of the positions.

Per Rule 129.6 (b) of the Texas Administrative Code:

(b) An employer may offer an employee a modified duty position, which has restricted duties, which are within the employee's work abilities as determined by the employee's treating doctor. In the absence of a Work Status Report by the treating doctor an offer of employment may be made based on another doctor's assessment of the employee's work status provided that the doctor made the assessment based on an actual physical examination of the employee performed by that doctor and provided that the treating doctor has not indicated disagreement with the restrictions identified by the other doctor.

Rule 129.6 (c) of the Texas Administrative Code states:

An employer's offer of modified duty shall be made to the employee in writing and in the form and manner prescribed by the Commission. A copy of the Work Status Report on which the offer is being based on shall be included with the offer as well as the following information:

- (1) the location at which the employee will be working
- (2) the schedule the employee will be working;
- (3) the wages the employee will be paid;
- (4) a description of the physical and time requirements that the position will entail; and
- (5) a statement that the employer will only assign tasks consistent with the employee's physical abilities, knowledge, and skills and will provide training if necessary

To reiterate, please forward what the employer purports to be a "Bona Fide Offer of Employment" to the employee's <u>treating doctor</u>. Please make sure it meets the requirements set forth in Rule 129.6 of the Texas Administrative Code.

Claimant's Treating Doctor: 713-660-9123 Dr. David Dent 5409 Bellaire Bellaire, TX 77401 I can be reached via e-mail at <u>Fyodor.Clay@ogletreeabbott.com</u> or via telephone at the number listed above, ext 128. Thank you for your attention to this matter.

Sincerely



CERTIFIED MAIL RETURN RECEIPT REQUESTED

June 18, 2008

| Farrier Riley (b) (4) | |
|-----------------------|--|
| | |

TEXAS MUTUAL CLAIM

modified job assignment.

Dear Farrier Riley,

CES Environmental Services, Inc. would like to offer you a temporary, modified job duty assignment at the facility Tank Wash area, located at 4904 Griggs Rd in Houston, Texas. The schedule for this position is 3:00 pm to 11:00 pm Monday through Friday, and the job pays per hour, which is your current rate of pay. The job duties meet the work restrictions certified by the emergency room physician at St. Luke's Episcopal Hospital, whose work status report is attached.

The job involves assisting logistics with coordination of transport vehicles. Your duties will involve sitting at the work station and walking the facility yard. This job will not require lifting and is consistent with the physician limitations.

While assigned to this modified -duty job position we will only assign tasks that are consistent with your physical abilities, knowledge and skills. Training will be provided as necessary.

Please contact me as soon as possible if you are willing to accept this temporary,



Employee - You are required to report your injury to your employer within 30 days if your employer has workers' compensation insurance. You have the right to free assistance from the Texas Department of Insurance, Division of Workers' Compensation and may be entitled to certain medical and income benefits. For further information call your local Division field office or 1(800)-252-7031.



TEVAS MODIFICATION MODE STATUS DEPORT

risa Workers Comp

Empleado - Es necesario que reporte su lesión a su empleador dentro de 20 días a partir de la fecha en que se lesionó si es que su empleador cuenta con un seguro de compensación para trabajadores. Usted tiene derecho a recibir asistencia grativita por pare de la División de Compensación para Trabajadores, y también que de tener derecho a cientos b entellos médicos y monetanos. Para mayor información comuniquese con la oficina local de la División al Teléfono 1-800-252-7031.

| | KS CUMPENSATION WORK ST | |
|---|--|---|
| PART I: GENERAL INFORMATION | opdar's Name and Degree D. Parsons of | or transmission purposas only) Cale Being Sent |
| Law Di ley | Premier (hiropractic) | Employer Warme Environmento |
| 2. Date of Injury (5 - 7 7 - 0 8 b) (4) | | D. Employer's Fax # or Email Address (if known) |
| | inicFacilityDoctor Address (street address) | 1. Insurance Carrier |
| and truck | Pearland TX 17584 | Carrier's Fax # or Email Address (if known) |
| PART II: WORK STATUS INFORMATION (FI | | AND DESCRIPTION IN 1991 AS APPLICABLE) |
| 13. The injured employee's medical condition result (a) will allow the employee to return to work (b) will allow the employee to return to work a | | ified in PART III, which are expected to last |
| 6-17-(date). The following describ | es how this injury prevents the employee from ret | uming to work: |
| PART III: ACTIVITY RESTRICTIONS* (ONL) | COMPLETE IF BOX 13(b) IS CHECKED) | |
| 14. POSTURE RESTRICTIONS (if any): | 17. MOTION RESTRICTIONS (if any): | 19. MISC. RESTRICTIONS (if any): |
| Max Hours per day: 0 2 4 6 8 Other | Max Hours per day: 0 2 4 6 8 Other | Max hours per day of work: |
| Standing ODDDD | Walking DDDDD | Sit/Stretch breaks ofper |
| Sitting O O O O | Climbing stairs/ladders 🚨 🗖 🚨 🚨 💆 🗆 | ☐ Must wear splint/cast at work |
| Kneeling/Squatting | Grasping/Squeazing | Must use crutches at all times |
| Bending/Staoping Q Q Q Q Q | Wrist flexion/extension | No driving/operating heavy equipment |
| Pushing/Pulling | Reaching | Can only drive automatic transmission |
| Twisting | Overhead Reaching | No work / [i] nours/day work: |
| 15. RESTRICTIONS SPECIFIC TO (if applicable): | nacan | at heights or on scaffolding |
| L Hand/Wrist R Hand/Wrist | Other: 18. LIFT/CARRY RESTRICTIONS (if any): | ☐ Must keep |
| □ LArm □ RArm □ Neck | May not lift/carry objects more thanlbs. | ☐ Elevated ☐ Clean & Dry |
| Dileg DRLeg DBack | for more than hours per day | No skin contact with: |
| L Foot/Ankle R Foot/Ankle | May not perform any lifting/carrying | D Oressing changes necessary at work |
| Other | Other: | No Running |
| 16. OTHER RESTRICTIONS (if any): | | 20. MEDICATION RESTRICTIONS (if any): |
| | | Must take prescription medication(s) |
| | | Advised to take over-the-counter meds |
| These restrictions are based on the doctor's best under particular restriction does not apply, it should be disregal available, the patient should be considered to be off work. as well as at work. | rded. If modified duty that meets these restrictions is not | Medication may make drowsy (possible Safety/driving issues) |
| PART IV: TREATMENT/FOLLOW-UP APPO | DINTMENT INFORMATION | |
| 21. Work Injury Diagnosis Information: 22. Ex | spected Follow-up Services Include: | |
| | raluation by the treating doctor on | (date) at ;am/pm |
| | 111 | in (date) at : am/pm |
| | nysical medicine 5 X per week for weeks starting | |
| 1 | pecial studies (list): pain DOCTOV | on (date) at : anvpm |
| Date / Time pi Visit EMPLOYEE'S SIGNATURE | one. This is the last scheduled visit for this problem. [DOCTOR'S SIGNATURE Visit Type: | |
| Discharge Times Factures Riller | General Per States | Designated doctor |
| AIC EOPAL73 (Rev. 10/05) Page | | DIVISION OF WORKERS: COMPENSATIO |

DWC FORM-73 (Rev. 10/85) Page



ST LUKES DISCHARGE INSTRUCTIONS

Name: Riley, Farrier D
Age: 33Y DOB: 0 (4)
Gender: M - Wt: 108.9 Kg
Medred (5) (4)
Acct: 0815000452
Attending: MCA
Bed: ED C ED2

It is important you read and follow the discharge instructions below carefully. If your symptoms change, become worse, or you develop new symptoms that cause concern, call-your doctor or return to the Emergency Department or a Community Emergency Center.

POLLOWUP CONTACTS

SPECIAL INSTRUCTIONS

Follow-up with your doctor in 24-48 hours if not improving.

Otherwise, see your doctor next week.

Have your doctor review all results + records from your ER evaluation/treatment

Return if symptoms worsen.

MEDICAL INSTRUCTIONS

BACK PAIN & INJURY-EI

HYPERTENSION

PRESCRIPTIONS

Vicodin: Tablet: 500 Mg-5 Mg: Oral

Dispense: 20, Quantity: 1-2, Schedule: Every 4 to 6 hours

If you were directed to follow-up with your doctor or a specialist, make your appointment as soon as possible. When calling for your appointment, let the office know you were referred after an emergency department visit.

After going home if you feel unsafe, and you may hurt yourself or others, call 911 or go to the nearest Emergency Department.

SUPPORT AND HELP BY PHONE:

Suicide Prevention Lifeline (800) 273-TALK (8255) Council on Alcohol and Drugs Houston (713) 942-4100

Poison Control Center (800) 222-1222

Can we help you find the doctor that's right for you? Call the:

ST. LUKE'S Physician Referral Line (832) 355-4343

Kelsey-Seybold Clinic

(713) 442-0000 (may call 24 hours a day)

St. Luke's Emergency Services

Main Emergency Department: 832-355-2121

Community Emergency Center Holcombe: 832–355–7525 Community Emergency Center San Felipe: 713–267–7100

COMING SOON! Community Emergency Center Pearland – SUMMER 2008

www.stlukestexas.com

Prepared: Thu May 29 2008 15:51 by MCA 1 of 1 Copyright 2006. Picis.

DWC FORM-6 Supplemental Report of Injury

DWC requires the reporting of all Return to Work and Post-Injury Change of Earnings. An injured worker is entitled to temporary income benefits if he/she has disability (defined as the inability to work, or the inability to earn wages equivalent to pre-injury wages, as a result of the injury) and has not reached maximum medical improvement (defined as having reached 104 weeks from the eighth day of lost time or when a doctor certifies that no further recovery can be reasonably anticipated). The insurance carrier shall adjust the weekly amount of temporary income benefits paid to the injured worker to match the fluctuations in weekly earnings after the injury. To ensure the insurance carrier has accurate information to calculate benefits, the DWC FORM-6 is to be completed as applicable:

By EMPLOYER

By INJURED WORKER If you (the INJURED WORKER) are no longer employed by the

employer where the injury/illness occurred, then you are

responsible to provide information to the workers' compensation

The EMPLOYER means the employer for whom the injured worker was working when the injury occurred. If the employer is the current employer, then you are responsible to provide information to the workers' compensation insurance carrier about:

insurance carrier about: The existence of earnings, and

The existence of earnings, and The amount of any earnings, or

The amount of any earnings, or

Any offers of employment.

Any offers of employment.

Include CLAIM and insurance carrier numbers in right upper hand corner. Complete items 1-21, sign and date.

This form may be used to do so. Include CLAIM and insurance carrier numbers in right upper hand corner. Complete items 1-4, 10-21, sign and date.

The EMPLOYER must file this form:

If you are employed by a new employer after the injury; and

- For a worker's injury/illness that occurs after January 1, 1991 and required the previous filing of a DWC FORM-1, Employer's First Report of Injury; and
- You are receiving benefits, you must tell the insurance carrier if your wages change, regardless of whether your income went up or down; or
- During the time the injured worker is entitled to temporary income benefits (TIBs); and
- You are not receiving benefits, you must tell the insurance carrier if the injury causes you to miss work or lose income.

- Until the injured worker:
 - - Reaches maximum medical improvement (MMI), or
 - Is no longer employed by the employer.

his report must be filed in the following situations within the timeframes indicated:

- 3 days after the injured worker begins to lose time from work as a result of the injury, if lost time did not occur immediately following the injury:
- 3 days after the injured worker returns to work;
- 3 days, when the injured worker returned to work, then later has additional day(s) of lost time as a result of the injury;
- 10 days after the end of each pay period in which the injured worker has a change in earnings as a result of the injury;
- 10 days after the injured worker resigns or is terminated.

While most of the sections on this form are self-explanatory, please note that the pay periods requested in sections 20 & 21 may be different depending on the situation for which the form is being filed:

- If the report is indicating lost time from work or the end of employment, the pay period shall be the most recent pay period prior to the lost time.
- If the report is indicating return to work or a change in earnings, the pay period shall be the pay period the injured worker is beginning.

This form is to be filed by first class mail or personal delivery with:

- The insurance carrier, and
- The injured worker.

This report is considered filed when personally delivered or postmarked.

This form is to be filed by first class mail or personal delivery

The insurance carrier.

This report is considered filed when personally delivered or postmarked.

If you return to work for the same employer or a different employer, your temporary income benefits from the insurance carrier must be adjusted.

Failure to report earned wages and/or offers of employment to the insurance carrier who is paying benefits to you is a crime that may result in fines and/or imprisonment.

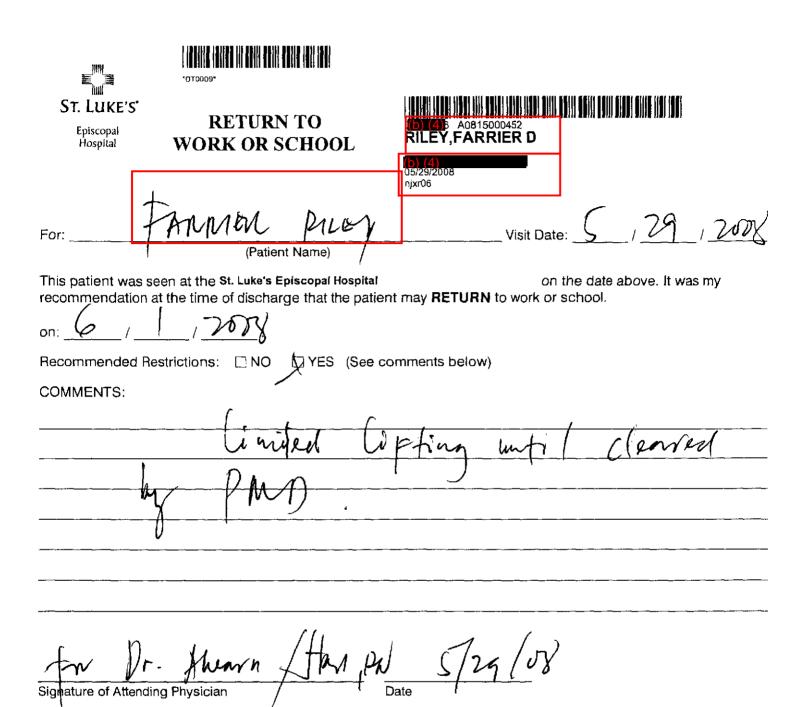
Failure to comply with these filing requirements, without good cause, is a Class D administrative violation, subject to a penalty not to exceed \$500.

TLC § 409.005 and Rules 120.3 and 129.4 provide the requirements regarding use of this report. The complete rule text is available on the DWC



DWC FORM-6 (Rev. 10/05) Page 2

DIVISION OF WORKERS' COMPENSATION



Return to work/school letter valid for this visit only

For additional time beyond date stated above, please contact Primary Care Doctor for follow-up appointment

6720 Bertner Avenue

Houston, TX 77225-0269

713-785-8537

GSA Accident and Near Miss Report

Confidential Report

Section 1. Please print or type in all information. Please use black ink only. This report must be completed within 24 hours of the Illness/Injury/Incident and forwarded to the Human Resources Department.

| | sted is required on | | | | | | |
|---|--|------------------------------------|---|-----------------------|---|--|--|
| Name of Person Involv | ed | | S∈ | 3X | Social Security Nur | nber | b) (4) |
| Energiae ? | $\mathbf{v} = \mathbf{v} \cdot \mathbf{v}$ | | 1 | 1 | (b) (4) | | D) (4) |
| tarrier 1 | D. Kiley | | ٠, | :) • | lame (if applicable) | | |
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| Home Address | | | \sim | ow i th | Cirv | 1704 | State |
| | | _ | | | (b) (4) | | 31378 |
| (b) (4) | | | | | | | |
| | | | | | | | |
| County of Residence | Phone | | | } | Employee's Occup | ation Facility | İ |
| | (281) | - | | 1- | | ľ | |
| } | <u> </u> | | | | Truck De | ver | |
| Date of Hire | Experience in Occu | pation at Time | of Inc | ident | Date of Incident | Time of Incident | Date Incident |
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| Employee was Workin | g Employir | ent Category | | | Phase of Empl | oyee's Workday at Time | of Injury |
| ☑ Alone | 7/n- | ılar, full-time | - | | O O o of a comit o o | Taladi Bustan | CT Couries Baseli Carded |
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| Specific Location of In- | cident | | | | - \ | | Was it on the |
| Office | Elevator | | | .ab | \Box | Press Building | Employer's Premises? |
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| Lost Work Days | ☐ Other | | _ | Date | s away from work # tricted work days # e returned to work | | Doctor |
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| Body Part Affected (B) | e very specific): | | | _ | _ | accident? | ve done to prevent this |

GCA Accident and Near Miss Report

Confidential Report, page 2

| Witness Statement (if applicable) If more than one witne | ss, attach a separa | ale sheet. | | <u> </u> |
|--|-------------------------------|---|--|--|
| | | | | |
| Witness Signature and Date | | · Pt | none # | |
| Section 2To be completed by Supervisor/Manage Supervisor's Description of Incident. | r or Safety Coord | inator | | |
| | | | | |
| | | | | |
| | 1 71 | م ومر | | |
| Supervisor's Name and Signature and Date (hes | teds | emen | Witnessed Incident? | Yes OM6 |
| -Winar-copromignegis roots-Equipment xor Work Ates .C vine incident/west to the control of Mot Applicable | oninibited to a | | a All Payor Applicable | |
| ☐ Hazardous Placament ☐ Inadequate Guards ☐ Floors/Work Space ☐ Defective Tools/Edition ☐ Equipment/Workst | uip/Vehicle | ☐ Abuse or Misuse ☐ Inadequate Maintenan ☐ Lack of Knowledge/Tra | | ork Surfaces Guards/Barriors xols/Equip/Vehicle |
| ☐ Illumination ☐ Inadequate/Improp ☐ Equipment Failure ☐ Close Clearance/C ☐ Inadequate Housekeeping ☐ Inadequate Warnin | ongestion | ☐ Inadequate Supervisio ☐ Inadequate Tools/Equi ☐ Inferior Equipment | n 🔲 Illumination | Improper PPE |
| What action of inaction contributed to the incident? | | a er ayentauvenneasures | No. Applicatio | |
| ☐ Failure to Make Secure ☐ Under influence Di ☐ Used Equipment Improperty ☐ Operating Procedu ☐ Improper Loading ☐ Servicing/Operating | rugs/Alcohol are Deviation | ☐ Improve Enforcement ☐ Repair/Replace Equip | ☐ Task Analys ment ☐ Use Other N | is to Be Completed Materials/Supplies |
| ☐ Improper Technique ☐ Running/Rushing// ☐ Failure to Warn/Signal ☐ Used Wrong Tool// | Acting in Haste Equipment | ☐ Idenlify/Improve PPE☐ Improve Design/Const☐ Improve Illumination | truction 📋 Reassign Jo Mandatory F | e Guarda/Dévices ob of Employee Pre-Job Instructions |
| ☐ Used Defective Equipment ☐ Inadequate/Improp ☐ Improper Lifting ☐ Operating at Impro ☐ Unauthorized Actions ☐ Nullified Safety/Co | per Speed | ☐ Re-instruction of Empl ☐ Rotation of Employee ☐ Improve Ventilation | ☐ Task Analys | ange Work Melhod iis/Procedure Revision |
| ☐ Improper Position ☐ None ☐ Horseplay/Distractive Action ☐ Other | HUO DEVICES | Corrective Counseling Eliminate Congestion | improve Sto | rage/Arrangement an-Up Procedures |
| Specific Corrective Actions or Preventative Measure | s:Taken : ** North | | | |
| Corrective Action Taxen | | esponsible | Target Date | Date Completed |
| | | | | |
| | | | | |
| Supervisor' Signature | Date | Manager's Signature | | Date |
| Safety Coordinator Signature | Date | Received in HR by | and the state of t | Date |



GULF COAST WASTE DISPOSAL AUTHORITY

WASHBURN TUNNEL FACILITY 1002 N. RICHEY PASADENA, TX 77506-1041

| FAX TDANSA | AITTAL | PHONE: FAX: | 713-472-5507 713-472-3309 |
|-----------------------------------|----------------------|----------------|------------------------------|
| TO: | Chris e CES Transpo | rT | |
| FAX NO. | 713 676 1676 | | |
| FROM: | Clark Wolfe e G.C.A. | | |
| DATE: | 5-22-08 | | _ |
| RE: | Accident Report for | 5-22-0 | <u> </u> |
| Number of pages (including cover) | 4 | | |
| COMMENTS: | | | |
| | | <u> </u> | |
| | | | |
| | | | |

CONFIDENTIALITY NOTICE

The documents accompanying this facsimile transmission may contain confidential information which is privileged. The information is intended to be reviewed initially by only the individuals named above. If you have received this facsimile in error, please immediately notify this office by telephone to arrange for the return of the original documents to us at our expense. You are hereby notified that any disclosure, copying, distribution or the taking of any action in reliance on the contents of this facsimile is strictly prohibited.



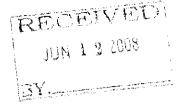
Claim & Information Services P.O. Box 12029

Austin, TX 78711-2029

1-800-859-5995 (512) 224-3800

Fax (512) 224-3889

June 9, 2008



C E S ENVIRONMENTAL SERVI

4904 GRIGGS RD HOUSTON, TX 770213208

Re:

Claim #: Employee: Soc. Sec.: Employer:

Date of Injury:
DWC #:

(b) (4)

FARRIER RILEY
(b) (4)

C E S ENVIRONMENTAL SERVI

05/22/2008

In accordance with the Division of Workers' Compensation Rules, we are requesting that you submit the information indicated below. The DWC3 and DWC6 forms are available for printing from our website, www.texasmutual.com, under services, or from the division's website, www.tdi.state.tx.us. For your convenience, a DWC3 is now available for you to complete and submit on-line. It is located on our website, www.texasmutual.com under the Employers - Loss Run & Claims Detail Section. If you need assistance with filing the DWC3 on-line please contact me. If you do not have access to the Internet, we will be happy to send you a blank form.

DWC3 EMPLOYER'S WAGE STATEMENT (Rule 128.2) - Please fax or email attachment or use the on-line version (www.texasmutual.com).

OR

 \Box

DWC3SD EMPLOYER'S WAGE STATEMENT FOR SCHOOL DISTRICTS (Rule 128.7)

DWC6 EMPLOYER'S SUPPLEMENTAL REPORT OF INJURY OR ILLNESS (Rule 120.3) - Please fax or email attachment. The following time frames apply.

Within 10 days after:

- The end of each pay period in which the employee's earnings have changed as a result of the injury, OR
- The employee resigns or is terminated.

Within 3 days after:

- The employee begins to lose time from work as a result of the injury, OR
- The employee returns to work, OR
- The employee, after returning to work experiences an additional days(s) of disability as a result of the injury.

Failure to provide the required information is an administrative violation and may result in the assessment of a penalty from the Division of Workers' Compensation.

AND

EMPLOYEE ACKNOWLEDGEMENT OF WORKERS' COMPENSATION NETWORK FORM (This form(s) shall be completed, signed and submitted). Please fax or send attachment via email as soon as possible.

Thank you for your prompt attention to this matter. If you have any questions, please call me at 1-800-859-5995 ext. 2231.

Sincerely,

Martha C. Coibion

WORKERS' COMPENSATION SPEC I



4904 Griggs Road Houston, TX 77021 Phone: (713) 676-1460 Fax: (713) 676-1676



To: Texas Mutual

From: Karl Guidry

(b) (4)

Fax: 1-512-224-3889

Pages: 25 Pages to follow

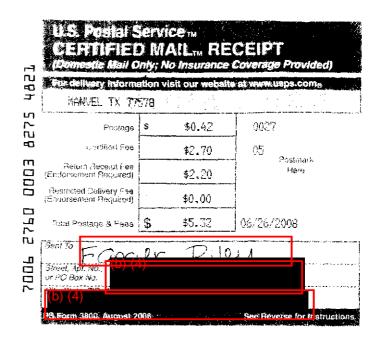
Attn: Debbie Garrett

Date: June 26, 2008

See attached documentation regarding our employee Farrier Riley. Be advised a certified mailing of the bona fide employment offer signed by Dr. Dent will be sent to Mr. Riley.

Karl Guidry CES Environmental Services, Inc. HSE Manager 4904 Griggs Rd Houston, Texas 777021

713-676-1460 Ext 115 713-676-1676 Fax kguidry@cesenvironmental.com



FOSTER PLACE STATION HOUSTON, Texas 770219998 4841490027-0096 06/26/2008 (800)275-8777 04:46:15 PM = Sales Receipt Final Sale Unit Product Price Qty Price Description \$0.42 MANVEL TX 7757B Zone-1 First-Class Letter 0.90 oz. \$2.20 Return Ropt (Green Card) \$2.70 Certified 70062760000382754821 Label #: _____ \$5.32 Issue PVI: ======== \$5.32 Total: Paid by: \$5.32 Cash Order stamps at USPS.com/shop or call 1-800-Stamp24. Go to USPS.com/clicknship to print shipping labels with postage. For other information call





CERTIFIED MAIL RETURN RECEIPT REQUESTED

| June 26, 2008 | |
|---|---|
| Farrier Riley (b) (4) | |
| assignment at the facility Tar The schedule for this position job pays (b) (4) per hour, wh | Inc. would like to offer you a temporary, modified job duty like Wash area, located at 4904 Griggs Rd in Houston, Texas. In is 3:00 pm to 11:00 pm Monday through Friday, and the lich is your current rate of pay. The job duties meet the work mergency room physician at St. Luke's Episcopal Hospital, ttached. |
| will involve sitting at the wo | gistics with coordination of transport vehicles. Your duties rk station and walking the facility yard. This job will not nt with the physician limitations. |
| consistent with your physical assignment has been certified | ied —duty job position we will only assign tasks that are abilities, knowledge and skills. This modified-duty job by your treating physician, Dr. David Dent, 5409 Bellaire, g will be provided as necessary. |
| Fide Employment Offer, if ye assignment. If we do not hea | nental Services, Inc within 5 days of receipt of this Bona ou are willing to accept this temporary, modified job or from you within 5 days of your receipt of this notice, we reinterested in continuing your employment with CES, Inc. |
| Accept | Date |

Decline ______Date____

| (name and fax number of camer) | |
|--------------------------------|--|



| TWCC# | |
|------------------|--|
| CARRIER'S CLAIM# | |

| ☐ Initial ☐ Amended | EMPLOYER'S WAGE STATEMENT |
|---------------------|---------------------------|
|---------------------|---------------------------|

The Texas Workers' Compensation Act and Commission rules require an employer to provide an Employer's Wage Statement to its workers' compensation insurance carrier (carrier) and the claimant or the claimant's representative, if any. The purpose of the form is to provide the employee's wage information to the carrier for calculating the employee's Average Weekly Wage (AWW) to establish benefits due to the employee or a beneficiary.

The AWW is based on the wages the employee earned in the 13 weeks immediately preceding the date of injury (or the wage a similar employee earned if the employee did not work the full 13-week period). "Wages" include all forms of remuneration payable to an employee for personal services, including fringe benefits. To simplify filing, employers may file wages in a monthly, biweekly, or weekly manner as discussed below.

NOTE - An employer who fails without good cause to timely file a complete wage statement as required by the Texas Workers' Compensation Act, Texas Labor Code, Section 408.063(c) and Commission Rule 120.4 may be assessed an administrative penalty not to exceed \$500.00 for an initial offense and not to exceed \$10,000.00 for a repeated administrative violation.

The employer shall timely file a complete wage statement in the form and manner prescribed by the Commission.

- (1) The wage statement shall be filed ("filed" means received) with the carrier, the claimant, and the claimant's representative (if any) within 30 days of the earliest of:
 - (A) the employee's eighth day of disability;
 - (B) the date the employer is notified that the employee is entitled to income benefits;
 - (C) the date of the employee's death as a result of a compensable injury.
- (2) The wage statement shall also be filed with the Commission within seven days of receiving a request from the Commission (Only When Requested).
- (3) A subsequent wage statement shall be filed with the carrier, employee, and the employee's representative (if any) within seven days if any information contained on the previous wage statement changes (such as if the employer discontinues providing a nonpecuniary wage that was initially continued after the date of injury).

| | | All applicable TWCC | rules can be found at www.twcc.state.tx.us | | | | | |
|---|--|---|--|--|--|--|--|--|
| EMPLOYEE AND EMPLOYER INFO | RMATION | | | | | | | |
| हिmployee's Name (Last, First, M.I.): | | Employer's Business Nam | ne: | | | | | |
| Riley Farrier D. | | CES Envico | n mental Services Suc ses (Street or P.O. Box): | | | | | |
| Employee's Mailing Address (Street or P.O. Box): | | Employer's Mailing Addres | ss (Street or P.O. Box): | | | | | |
| (b) (4) | | Ugou Griggs | Rd | | | | | |
| (b) 74) | ZIP Code: | City: | State: ZIP Code: | | | | | |
| (b) (4) | | 4 JOU STON Federal Tax I D Number | TX 77021 | | | | | |
| Social Security Number: | | | | | | | | |
| (b) (4) | | 16-059298 | | | | | | |
| Date of Hire: Date of Injur | ry: | Name and Phone # of Per | son Providing Wage (information: | | | | | |
| 4-16-08 | | | | | | | | |
| As of today's date, the employee is not back. The employee returned to work on without restriction. OR with restrictions and is earning wages of week/month (circle one). | and is working: | I HEREBY CERTIFY THAT this wage statement is complete, accurate, and complies with the Texas Workers' Compensation Act and applicable rutes, and the listed wages include all pecuniary and nonpecuniary wages paid for (earned in) the 13 weeks prior to the date of injury (as described on page 2) and I understand that making a misrepresentation about a workers' compensation claim is a crime that can result in fines and/or imprisonment. | | | | | | |
| NOTE - Rule 120.3 requires the employer file the Injury (TWCC-6) to report changes in Work Status ar | | Signature; | Date: | | | | | |
| EMPLOYMENT STATUS AT TIME OF | FINJURY (Check A | II That Apply) | | | | | | |
| Full-time: employee who regularly works at least 30 hours per week and whose schedule is comparable to other employees of the company and/or other employees in the same business or vicinity who are considered full-time. Seasonal: employee who as regular course of conduct engages in seasonal or cyclical employment that may or may not be agricultural in nature and that does not continue throughout the year. | employee whose work period preceding the inju worked part-time during t Part-time: Not Reguenployee whose work period preceding the injuitime work during that period prentice: employee | ular Course of Conduct: history for the 12-month ry shows part-time and full iod. be who is learning a skilled all experience under the | Minor: employee less than 18 years of age and not emancipated by marriage or judicial action who is also an apprentice, trainee or student. Student: employee enrolled in a course of study in high school, college or other institute of higher education or technical training. Trainee: employee undergoing systematic instruction and practice in some art, trade or profession with a view towards proficiency in it. | | | | | |
| SAME OR SIMILAR EMPLOYEE? | | If the employee was not a | employed for 13 continuous weeks before the date | | | | | |
| The wage information on this form is for: | | of injury, report the wages of an employee who has training, experience | | | | | | |
| The Injured Employee OR A Similar requested by the Commission, the employer s employee whose wages were provided.) | Employee (NOTE - If the similar | skills & wages comparable to the injured employee AND who performs services/tasks comparable in nature and in number of hours. If no similar employee exists, report the limited available wages earned by the injured employee prior to the injury. | | | | | | |
| NOTE TO INJURED EMPLOYEE - If you were injured provide your insurance carrier with wage information Contact your carrier for additional information or call | n from your other employm | nent for the carrier to includ | le in your AWW and this may affect your benefits. | | | | | |

TWCC-3 (Rev. 07/04) Page 1 of 2



TEXAS WORKERS' COMPENSATION COMMISSION

| WAGE INF | ORMA" | TION I | NSTR | UCTION | S | Rik | er, F | arrier | | 4 | Social Si م | ecurity #: 47-39 | حاحاة | Di | ate of injury | <i>(</i> : |
|---|------------------------|--------------------|---------|------------------------|-------------------------|---|--|---|--|---|--|---|---|--|---|---|
| 4.34821. If th | / provide le employ | wages yee is pa | for the | 3 months a biweekly | preceding basis, the | weeks im: the date amployer | mediately of injury. I may provid | preceding Monthly wa le the wage | the date iges may a s for the 1 | of injury. also be co 4 weeks p | If the em nverted to preceding t | ployee is weekly wa he date of | paid on a r ges by divi injury. Wh | iding the gr en setting t | oss mont ne period: | thly basis, the hiy amount by s to report, the mployer shall |
| not report wa | veekly ea | mings, i | use all | 13 Period (| Cotumns b | elow. If re | porting 3 m | onths of e | arnings, eit | her conver | the wage | s to weekly | earnings o | or use the fi | rst 3 Perio | od Columns, If |
| reporting 14 w | eeks of b | oiweekly | earnin | gs, use the | first 7 Per | riod Calum | ns. in all c | ases, indi | cate the d | ates that e | ach perio | d covers. | | | | |
| PECUNIAR | Y WAG | SE INF | ORMA | ATION | | nourly, we commission commission use of the | eekty, biwee ons. Eamin ons) need to employee's | kly, monthly gs are repo be prorated equipment | r, etc. wage: orted in the l. Pecuniary or for paying | s; salary; tip periods the rwages don g hetpers or | os/gratuities y are earne it include pa to reimburs | piecework d, NOT who lyments made e for travel | compensation in they are le by an emp | in; monetary paid and so ployer to reim consider as e | allowance me (such : burse the e amings an | re not limited to: s; bonuses; and as bonuses and amployee for the bounts from paid not used |
| PERIOD # (V Month #, or E | | #\ | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | |
| FROM DATE | | | 1/13 | 4/20 | 4/27 | 5/4 | 5/11 | 5/18 | 5/25 | 6/, | 4/8 | 4/15 | 4/22 | | | |
| TO DATE: | | | 119 | 4/26 | 5/3 | 5/10 | 5/17 | 5/24 | 5/31 | 4/7 | 6/14 | 4/21 | 4/28 | | | TOTALS |
| # HOURS W | | - 4/ | 007 | 66.13 | | 10419 | 14/13 | 41.19 | 17.16 | 9110 | 0 | P | 0 | | | 71317 |
| GROSS WAG EARNED: | GES | (D) | (+) | | | | | | | | | | | | | |
| NONPECU | NARY I | WAGE | INFO | RMATIC | | | | | | | | | an money. v the emplo | | | not limited to, the enefits. |
| Nonpecuniary Wage Type | Empl Provide | | Sp | ecify Valu | e Or Amo | | d in Each | | | | nefit Provi | ded Prior | To Injury | Will E | mployer | Date Benefit |
| 1 | To Inj | | | | | | (Use the s | ame perioc | is as used | apove) | | | | Cont | inue To vide? | Suspended (if suspended) |
| | | | 1 | 2 | 3 | | 5 6 | ame period | s as used | above) | 10 | 11 1 | 2 13 | Cont Pro | nue To | Suspended |
| Health Insurance | To Inj | jury? | 1 | 2 | 3 | | | | | | 10 | 11 1 | | Cont Pro | nue To vide? | Suspended |
| Health Insurance Laundry/ Cleaning | To Inj | jury? | 1 | 2 | 3 | | | | | | 10 | 11 1 | | Cont Pro | nue To vide? | Suspended |
| Health Insurance Laundry/ Cleaning Clothing/ Uniforms | To Inj | jury? | 1 | 2 | 3 | | | | | | 10 | 11 1 | | Cont Pro | nue To vide? | Suspended |
| Health Insurance Laundry/ Cleaning Clothing/ | YES | jury? | 1 | 2 | 3 | | | | | | 10 | 11 1 | | Cont Pro | nue To vide? | Suspended |
| Health Insurance Laundry/ Cleaning Clothing/ Uniforms Lodging/ | YES | NO V | 1 | 2 | 3 | | | | | | 10 | 11 1 | | Cont Pro | nue To vide? | Suspended |
| Health Insurance Laundry/ Cleaning Clothing/ Unitoms Lodging/ Housing/ | YES | NO V | 1 | 2 | 3 | | | | | | 10 | 11 1 | | Cont Pro | nue To vide? | Suspended |
| Health Insurance Laundry/ Cleaning Clothing/ Uniforms Lodging/ Housing/ Food/ Meals | YES | NO V | 1 | 2 | 3 | | | | | | 10 | 11 1 | | Cont Pro | nue To vide? | Suspended |



1675 2 G 7908

Claim and Insurance Services P.O. Box 12020 Austin, Texas 78711-2029

NOTIFICATION OF FIRST TEMPORARY INCOME BENEFIT PAYMENT

DATE:

06/20/2008

TO:

RILEY, FARRIER

RE:

Date of Injury:

Nature of Injury:

Part of Body Injured:

Employee SSN:

DWC#:

Carrier Name:

Carrier Claim Number:

Employer:

05/22/2008

CRUSHING

MULTIPLE BODY PARTS(INCL.BODY SYSTEMS & BDY PARTS

462-47-3566

Texas Mutual Insurance Company

C <mark>E S ENVIRONM</mark>ENTAL SERVI

4904 GRIGGS RD

HOUSTON TX 77021-3208

Your first payment of workers' compensation benefits for the period of 05/23/2008 to 06/19/2008 is being issued. The benefit payment is called "Temporary Income Benefits" (TIBS) and is paid weekly. Entitlement to TIBs begin after you have had lost wages for more than 7 days. TIBs began on 05/30/2008 which was your eighth day of disability. The TIBs weekly benefit amount of \$712.00 is based on the reported Average Weekly Wage of \$1070.00.

Please inform us within 3 days if you:

Start earning income from the same employer, a different employer, or from self-employment; or Have any change in earnings resulting from your injury, either an increase or decrease; or Have an offer of employment at any wage level.

You are encouraged to contact your employer regarding any return to work program that will allow you to work within the restrictions prescribed by your treating doctor.

If you are expected to be paid benefits for a period of eight weeks or more, you may request that we make your benefit payments by electronic funds transfer directly to your bank account. Also, you may request that we change your TIBs from a weekly payment to a monthly payment.

Explanatory Comments: WAGE STATEMENT HAS BEEN REQUESTED.

If you do not agree with the amount of weekly income benefits being paid, please contact me:

DEBBIE K. GARRETT (800) 859-5995 (512) 224-3889

Adjuster's Name: Toll Free Telephone #:

Fax #/E-mail Address:

If we are unable to resolve the issue to your satisfaction, you may contact the Texas Department of Insurance, Division of Workers' Compensation for further assistance. You have the right to request a Benefit Review Conference. You can contact the Division office handling your claim at 1-800-252-7031.

If you would like to receive notices such as this by facsimile or e-mail, please contact me and provide your facsimile number or e-mail address.

Please note that making a false or fraudulent workers' compensation claim is a crime that may result in fines and/or imprisonment.

RILEY, FARRIER C E S ENVIRONMENTAL SERVI **BIANCA MARTINEZ**





June 20, 2008

Claim & Information Services P.O. Box 12029 Austin, TX 78711-2029

1-800-859-5995 (512) 224-3800 Fax (512) 224-3889

TOPETTO ETT

C E S ENVIRONMENTAL SERVI 4904 GRIGGS RD HOUSTON, TX 77021-3208

Re:

Claim #:

Social Security #:

Employee:

Employer:

Date of Injury:

FARRIER RILEY

C E S ENVIRONMENTAL SERVI

05/22/2008

Dear C E S ENVIRONMENTAL SERVI,

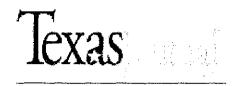
Please be advised that I am now handling the workers' compensation claim referenced above.

Please contact me if, due to the injury, a change in work status occurs which results in a change in the employee's earnings.

In addition, should you have any questions concerning this claim, please call me at 1-800-859-5995 ext. 2243. I look forward to talking to you.

Sincerely,

Debbie K Garrett WORKERS' COMPENSATION SPEC II



06/06/2008

C E S ENVIRONMENTAL SERVICES I 4904 GRIGGS RD HOUSTON TX 77021-3208

Notification Confirming Receipt of Claim

Date of Injury:

05/22/2008

Injured Worker:

RILEY, FARRIER

Claim Number:

Policy Number:

0001086044

Attached is a copy of the information another party reported to Texas Mutual Insurance Company which was used to establish this claim. You may submit additional claim information to Texas Mutual Insurance Company. If you have questions regarding this report of injury please contact us at (800) 859-5995.

If your policy includes our workers' compensation health care network option you are required by law to obtain a second Employee Acknowledgement of Workers' Compensation Network Form signed by the injured worker. Please submit a copy of the signed, second acknowledgement form to Texas Mutual Insurance Company. You can find a copy of the form online at www.texasmutual.com/hcn/hcn.shtm

Below please find information that will help you through the claim process:

To submit additional claim information:

To locate a treating doctor:

Mail to: P. O. Box 12029 Austin, Texas 78711-2029 www.texasmutual.com/workers/lwADL.shim

Fax to: (512) 224-3889

To contact the handling adjuster:

Call: (800) 859-5995

Monday - Friday: 8:00 a.m. - 5:30 p.m.

To obtain a copy of the Employer and Employee Rights and Responsibilities in the Workers' Compensation System:

www.texasmutual.com/employers/erRights.shtm

To locate a pharmacy, or for pharmacy questions, contact Scripnet.

Call: (888) 880-8562 www.scripnet.com

To obtain a copy of the Employer and Employee Rights and Responsibilities for the workers' comp health care network: www.texasinutual.com/hcn/hcn.shtm

Additional Texas Mutual® online services at www.texasmutual.com, available 6 a.m. - 9 p.m., include:

- o Obtain logon id, or for immediate logon id, call (800) 859-5995, M-F, 8:00 a.m. 5:30 p.m.
- Submit first report of injury in the Employers section 0
- Submit wage statement when reviewing loss runs and claim details
- Obtain specific claim summary information



Claim Number:

99J0000533279

Notification Date: 06/05/2008

EMPLOYER'S FIRST REPORT OF INJURY

INJURED EMPLOYEE

Name: FARRIER RILEY SSN: XXX-XX-3(b)

Mailing

Address:

County: BRAZORIA

Physical Address:

County:

Home Phone: Date of Birth: (b) (4

Marital Status: Unknown

Gender: Language: Male

Dependents: 00

English

MEDICAL PROVIDER

Name:

Tax ID:

Address:

Phone:

Ext:

Fax:

ATTORNEY

Represented by Attorney: Yes

Name:

Phone:

Fatality:

BUSINESS/EMPLOYER

Name: CES ENVIRONMENTAL SERVICES I

Address:

4904 GRIGGS RD

HOUSTON TX 77021-3208

Phone: (713)676-1460 Ext: Fax: (713)676-1676

Policy Number: 0001086044

FEIN:

760592985

Location ID:

EMPLOYMENT

Occupation:

Hire Date: 00/00/0000 State:

Partner/Officer/Owner:

Date Lost Time Began: 00/00/0000 Return to Work Date: 00/00/0000

Last Paycheck was:

Wage: Frequency:

Hours/Week:

Period Start: 00/00/0000

Period End: 00/00/0000

Days/Week:

Supervisor

Name:

Phone:

Ext:

PREPARER OF REPORT

Name:

Phone: Email:

Ext:

Fax:

INJURY INFORMATION

Date of Injury: 05/22/2008 Time: 00:00

Nature of Injury: UNKNOWN/NOT REPORTED

Date Reported: 05/22/2008

Address Where Injury Occurred: PASADENA TX

County: Witnesses:

Cause of Injury: CAUGHT IN/UNDER OR BETWEEN MACHINE OR

MACHINERY

MULTIPLE BODY Part of Body:

PARTS(INCL.BODY

SYSTEMS & BDY PARTS

Name: Phone:

Name:

Phone:

Name:

Phone:

How and Why the Injury/Illness Occurred

LUMBAR; LT WRIST; BOTH LEGS; CHEST; FOOT; "INJURED WHEN HE WAS CAUGHT INBETWEEN A TRUCK AND A GATE" PER DWC41. CLAIM CREATED FROM LEGAL DOCS

C E S ENVIRONMENTAL SERVICES I 4904 GRIGGS RD HOUSTON TX 77021-3208

> Texas Mutual Insurance Company P.O. Box 12029 Austin, TX 78711-2029 Phone: (800) 859-5995; Fax: (512)224-3889

¬프로프학자성학교회교회교회 (그림학생 학생기 (1) 4.4 FOSTER PLACE STATION HOUSTON, Teras 7 - 1/10938 48413 - 127-0035 06/18/2008 (8: :-8:77 0: 41:12 PM Product Final Description Price MANVEL TX 775.6 \$0.42 Zone-1 First-Clas. Letter 0.50 az. Return Ropt (Green \$2.20 Card) Certified \$2.70 Label #: 70053110000304914653 ======= Issue PVI: \$5.32 ------Total: \$5.32 Paid by: Cash \$20.32 -\$15.00 Change Due: Order tamps of HSB9.com/shop or to scint call thought th postage. For other atomas all - - - 0.000004000010

| U.S. Postal S CERTIFIED (Domestic Mail Of For delivery information of the company | MAnly; Notion vi | AIL _{IM} REC | at www.usps.com |
|--|------------------|-----------------------|-----------------|
| Postage | \$ | \$0.42 | 0027 |
| Certified Fee | \$2.70 | | 0/6 Postmark |
| Return Receipt Fee (Endorsement Required) | | \$2.20 | Hero |
| Restricted Delivery Fee (Endorsement Required) | | \$0.00 | |
| Total Postage & Fees | \$ | \$5.32 | 06/18/2008 |
| Sent To | ~ i e | VR | leu |
| treet, Apt. No.; | 4) | | |
| (D) (4) | | | ryglion |

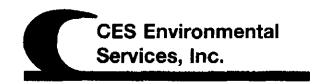
| SENDER: COMPLETE THIS SECTION | COMPLETE THIS SECTION ON DELIVERY |
|---|--|
| Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. Print your name and address on the reverse so that we can return the card to you. Attach this card to the back of the mailpiece, or on the front if space permits. Article Addressed to: | A Signature A Signature Addressee B. Received by (Printed Name) C. Date of Delivery D. is delivery address different from item 17 Yes If YES, enter delivery address below: |
| tarrier Riley (b) (4) | |
| | 3. Service Type ☐ Certifled Mail ☐ Express Mail ☐ Registered ☐ Return Receipt for Merchandise ☐ Insured Mail ☐ C.O.D. |
| | 1 Bastulated Ballions & (Even Enc) Yes |
| 2. Article (Trans | !595-02-M-1540 |





CERTIFIED MAIL RETURN RECEIPT REQUESTED

| June 18, 2008 | |
|--|---|
| Farrier Riley (b) (4) | |
| TEXAS MUTUAL CLAIM | |
| assignment at the facility Tank Wash are. The schedule for this position is 3:00 pm job pays (b) (4) er hour, which is your of | like to offer you a temporary, modified job duty a, located at 4904 Griggs Rd in Houston, Texas. to 11:00 pm Monday through Friday, and the current rate of pay. The job duties meet the work oom physician at St. Luke's Episcopal Hospital, |
| | coordination of transport vehicles. Your duties d walking the facility yard. This job will not ohysician limitations. |
| | b position we will only assign tasks that are nowledge and skills. Training will be provided |
| Please contact me as soon as possible if y modified job assignment. KARL A. GUIDRY CES Environmental Services, Inc. HSE Manager | ou are willing to accept this temporary, |
| Enclosed: TWC Work Status Report | |
| Accept | Date |
| Decline | Date |



4904 Griggs Road Houston, TX 77021 Phone: (713) 676-1460

Fax: (713) 676-1676



To: Texas Mutual From: Karl Guidry

(b) (4)

Fax: 1-512-224-3889 FAC Pages: Pages to follow

713-3(6-719)

Attn: Workers Comp Date: June 4, 2008

See attached documentation regarding our employee Farrier Riley.

Karl Guidry CES Environmental Services, Inc. HSE Manager 4904 Griggs Rd Houston, Texas 777021

713-676-1460 Ext 115 713-676-1676 Fax kguidry@cesenvironmental.com



4904 Griggs Road Houston, TX 77021 Phone: (713) 676-14

Phone: (713) 676-1460 Fax: (713) 676-1676



To: Texas Mutual From: Karl Guidry

(b) (4)

Fax: 713-316-2191 Pages: Pages to follow

Attn: Martha Date: June 24, 2008

See attached documentation regarding our employee Farrier Riley.

Karl Guidry CES Environmental Services, Inc. HSE Manager 4904 Griggs Rd Houston, Texas 777021

713-676-1460 Ext 115 713-676-1676 Fax kguidry@cesenvironmental.com ******* Date JUN-24-2008 **** Time 16:22 *******

Date/Time = JUN-24-2008 16:21

Journal No. = 151

Comm. Result = OK

Page(s) = 005

Duration = 00:00:38

File No. = 532

Mode = Memory Transmission

Destination = 7133162191

Received ID = /7133162191

Resolution = Fine

-CES ENVIROMENTAL -

**** DP-C264 *************

- **** - 7137488664- *******



4904 Griggs Road Houston, TX 77021 Phone: (713) 676-1460

Fax: (713) 676-1676



To: Dr. David Dent From: Karl Guidry

(b) (4)

Fax: 713-475-8688 Pages: Pages to follow

Attn: Date: June 24, 2008

See attached documentation regarding a modified job duty assignment for our employee Farrier Riley.

Karl Guidry CES Environmental Services, Inc. HSE Manager 4904 Griggs Rd Houston, Texas 777021

713-676-1460 Ext 115
713-676-1676 Fax
kguidry@cesenvironmental.com

******** -IND. XMT Journal- ********* Date JUN-24-2008 **** Time 16:19 *******

Date/Time = JUN-24-2008 16:18

Journal No. = 150

Comm. Result = OK

Page(s)

= 003

Duration

= 00:00:38

File No.

= 531

Mode

= Memory Transmission

Destination = 7134758688

Received ID = /7134758688

Resolution = Fine

-CES ENVIROMENTAL

***** DP-C264 *************

_ **** _

7137488664- ******





CERTIFIED MAIL RETURN RECEIPT REQUESTED

June 24, 2008

To:

Dr. David Dent

(4)

From: Karl Guidry

CES Environmental Services, Inc.

4904 Griggs Rd.

Houston, Texas 77021

Re:

Workers Comp Claim for Farrier Riley

TEXAS MUTUAL CLAIM

Dear Dr. Dent,

CES Environmental Services, Inc. would like to offer your patient, Farrier Riley a temporary, modified job duty assignment at the CES Environmental Services, Inc facility, located at 4904 Griggs Rd in Houston, Texas. This modified duty position meets the requirements of Rule 129.6 (a) of the Texas Administrative Code.

The schedule for this position is 3:00 pm to 11:00 pm Monday through Friday, and the job pays per hour, which is his current rate of pay. Please determine if the job duties describe below meet the work restrictions which you are willing to certify. Please be advised that as of this date we have received no indication of return to work recommendations from your office nor have we received any work status documentation from you regarding Farrier Riley.

The job involves assisting logistics with coordination of transport vehicles. Mr. Riley's duties will involve sitting at the work station and walking the facility yard to coordinate parking of tankers and rolling stock. This job will not require lifting or driving and we believe is consistent with any treating physician limitations.

While assigned to this modified –duty job position we will only assign tasks that are consistent with Mr. Riley's physical abilities, knowledge and skills. Training will be provided as necessary.



Please indicate if you are willing to certify this temporary, modified job assignment for Farrier Riley.

| I Certify (Sign) | Date |
|-------------------------|------|
| I do not Certify_(Sign) | Date |

Regards,

Karl A. Guidry

CES Environmental Services, Inc.

HSE Manager 4940 Griggs Rd.

Houston, Texas 77021

****** Date JUN-10-2008 **** Time 08:24 *******

Date/Time = JUN-10-2008 08:23

Journal No. = 139

Comm. Result = OK

Page(s)

= 002

Duration = 00:00:25

File No. = 323

Mode = Memory Transmission

Destination = 7133162191

Received ID = / 7133162191

Resolution = Fine

-CES ENVIROMENTAL

**** DP-C264 ************ -

_ ***** _

7137488664- *******



12600 N. Featherwood, Suite 200 Houston, Texas 77034-4440 Phone: (713) 223-1234 Fax: (713) 910-9010 Mail@OgletreeAbbott.com

> BIANCA MARTINEZ LESLIE LEVINGSTON ADRIENNE GASSER ENRIQUE VARELA

BY.____

BILL OGLETREE BILL ABBOTT CELINA RECALDE FYODOR CLAY

June 13, 2008

CES Environmental 4904 Griggs Rd. Houston, TX 77021

Re:

Our Client:

SSN:

Date of Injury:

Claim No.:

DWC No.:

Farrier Riley
(b) (4)

May 22, 2008
(b) (4)

Unknown-MI

Dear Sir or Madam:

We represent the above named employee in connection with his Workers' Compensation claim. Pursuant to the Texas Department of Insurance, Division of Workers' Compensation Rules, we request that you provide us with:

Employer's First Report of Illness or Injury (DWC-1): Filing of this form is not optional. Pursuant to Rule 120.2, the report (Employer's First Report of Injury Form DWC 1) shall be filed with the Division and the carrier, with a copy sent to the employee's mailing address, not later than the eighth day after the receipt of notice of occupational disease, or the employee's first day of absence from work due to injury or death.

Employer's Wage Statement (DWC-3): Filing of this form is also not optional. Per Rule 120.4 (a)(1), "An employer shall file a signed wage statement with the carrier and the injured employee or injured employee's representative within 30 days of the date benefits begin to accrue...." Subsection (e) of the same states. "An employer that fails to file a complete wage statement as required by this rule without good cause may be assessed an administrative penalty, not to exceed \$500, under the Act, 4.10(f)."

Pursuant to Rule 128.1(b), the following information regarding the employee's wages and benefits are important in the calculation of the injured employee's correct wages.

A. **Regarding overtime** - What were the hours worked 13 weeks prior to and up to the date of injury and the amount paid to the employee?

- B. **Health Insurance** Including prescription, dental, orthodontics and vision, what was the total amount being paid by your company? Was it being paid weekly or monthly? What was the date it was terminated?
- C. **Life Insurance** What was the amount being paid by your company? Was it being paid weekly or monthly? What was the date it was terminated?
- D. Vacation or Holidays What was the amount being paid by your company? What were the dates it was paid & terminated? Was it being paid weekly or monthly?
- E. **Safety Bonuses or any other honuses** What was the amount being paid by your company? What were the dates it was paid & terminated? Was it being paid weekly or monthly?
- F. Please list any other fringe benefits that were not included on wage statement.

If you have any comments please call me at the number listed above. Thank you for your prompt attention to this matter.

EPAHO043000261



4904 Griggs Road Houston, TX 77021 Phone: (713) 676-1460

Fax: (713) 676-1676



To: Texas Mutual From: Karl Guidry

(b) (4)

Fax: 713-316-2191 Pages: Pages to follow

Attn: Martha Date: June 24, 2008

See attached documentation regarding our employee Farrier Riley.

Karl Guidry CES Environmental Services, Inc. HSE Manager 4904 Griggs Rd Houston, Texas 777021

713-676-1460 Ext 115 713-676-1676 Fax kguidry@cesenvironmental.com ******* -IND. XMT Journal- ******** Date JUN-24-2008 **** Time 14:18 ******

Date/Time = JUN-24-2008 14:17

Journal No. = 143

Comm. Result = OK

Page(s)

= 006

Duration = 00:01:06

File No.

= 524

Mode

= Memory Transmission

Destination = 7133162191

Received ID = / 7133162191

Resolution = Fine

-CES ENVIROMENTAL -

***** DP-C264 *************

_ **** _

7137488664~ *******

RETURN TO WORK RECOMMENDATIONS

713 676 1676

BACK PAIN CHIROPHACTIC

2018 E. Broadway St. Pearland, TX 77581-5502

Telephone: (281) 485-2965

| PATIENT & NAME | FARAIRA | RILET | | | DATE 6-17-0 | ₹ |
|------------------|---------------------------------------|---------------------------------------|----------------------|-----------------------|------------------------------------|-----------------------|
| COMPANY | 1 months | KICET | | | DATE OF IRRIPY OR ILLNESS 5-22- | |
| REDNON | | · · · · · · · · · · · · · · · · · · · | ···· | | DATECHESS) | O Marine America |
| | | | | | | |
| RCATMENT RENO | ERED CKM | D #Ray D | Physicial Thoragy | 3 Manipulation 🖽 C | Office Viet D Obey | |
| i saw/treated | this patient on _ | 6-16-08 | | | | |
| 2 Patie | nt is unable to wo | rk at this time ar | nd will be reevalue | ted on $6 \cdot 2$ | 7-08 | ı |
| ☐ Patie | nt is able to work | with no limitation | na or restrictions o | n | | |
| Patler | nt is able to work | with the following | g restrictions: | | | |
| PATIENT IS | TO OBSERVE TI | HE FOLLOWING | LIMITATIONS: | | | |
| | ng with a limit of: | | | | | |
| | _ | 0-10 lbs. | 10-20 lbs. | 20-50 lbs. | ☐ 50-70 lbs. | ☐ 75 lbs. & over |
| | nding/walking with | | - | | _ | - |
| | | 1-2 hours | 3-4 hours | 4-6 hours | eruod 8-8 🔲 | |
| SINU | ng with a daily lim | it at: | | | - | |
| | None [| 1-2 hours | 3-4 hours | 4-6 hours | 🔲 6-8 hours | |
| Driv | ing with a daily lin | nit of: | | | | |
| | None | 1-2 hours | 3-4 hours | 4-6 hours | ☐ 6-6 hours | |
| Яер | etitive hand motio | ns to be avoide | d : | | | ∏ L e ft |
| | Grasping | Fine Manipu | lation | Pushing & Pulling | ☐ Rotation | Alight |
| Rep | etitive motions to | be avolded: | | | | <u>_</u> |
| | Bending | ☐ Squatting | | limbing [| Overhead reaching | ☐ Twinting |
| | Carrying | ☐ Stooping | □P | ushing [| Pulling | ☐ Kneeling |
| Othe | or restrictions; | | | | | |
| | | | | | | |
| | | | | | | |
| HESE RES | TRICTIONS ARI | E IN EFFECT L | INTL: 6-2 | 7- 38 0 | OR UNTIL PATIENT IS | REEVALUATED. |
| | | | | Date | | |
| | · · · · · · · · · · · · · · · · · · · | 2 | | Some D | .C. Date 6 | نان در ن |
| Poctor's Sign | Atura | / | | | Date 6 | 17-0 |
| THORIZATIO | ON TO RELEASE | INFORMATION | d: | *** | | |
| reby authori | ze my altending d | loctor to release | any information o | r copies thereof po | quired in the course of i | my examination and/or |
| minerity ICH ICH | anala matuuses (| andes to the em | ployer or his repre | >\$11 44(148) | | |
| ant's Signatu | f6 | | | | Date | |

Attn: Ryan FROM FARRIER Riley Re: Leave FROM WORK



Date 8/15/08

C E S ENVIRONMENTAL SERVI-4904 GRIGGS RD HOUSTON, TX 770213208

A BRC has been scheduled for the claim indicated below:

Employee: RILEY, FARRIER

Claim Number

Employer: C E S ENVIRONMENTAL SERVI

Date of Injury: 5/22/2008

DWC Number: 08272108

Docket Number: 08272108-01-BR

Adjuster: DEBBIE K. GARRETT Phone Number: 1-800-859-5995

BRC Date: 8/29/2008 BRC Time: 10:00 AM

Hearing Rep: Cheryl Thompson Phone Number: 713-376-1276

BRC Location: Division of Workers' Compensation - Missouri City

2440 Texas Parkway, Ste 240, Missouri City, TX, 77489

281-403-7050



| SENDER: COMPLETE THIS SECTION | COMPLETE THIS SECTION ON DELIVERY | | | |
|--|-----------------------------------|--|--|--|
| Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. Print your name and address on the reverse so that we can return the card to you. Attach this card to the back of the mailpiece, or on the front if space permits. 1. Article Addressed to: Complete items 1, 2, and 3. Also complete items 4. Print your hame and address on the reverse so that we can return the card to you. Attach this card to the back of the mailpiece, or on the front if space permits. 1. Article Addressed to: Complete items 1, 2, and 3. Also complete items 4. Print your hame and address on the reverse so that we can return the card to you. Attach this card to the back of the mailpiece, or on the front if space permits. 1. Article Addressed to: | A. Signature X | | | |
| Virticle Number 7006 2760 Pansfer from service label) | 0003 8275 4821 | | | |
| orm 3811, February 2004 Domestic R | eturn Receipt 102595-02-M-1540 : | | | |



4904 Griggs Road Houston, TX 77021 Phone: (713) 676-1460

Fax:

(713) 676-1676



то: Coventry From: Karl Guidry

(b) (4)

Fax: 1-877-504-4474

Pages: 1 Pages to follow

Attn: Mary Jane Date: August 1, 2008

See attached documentation regarding our employee Farrier Riley. Treating physician's return to work without restrictions are included.

Karl Guidry CES Environmental Services, Inc. HSE Manager 4904 Griggs Rd Houston, Texas 777021

713-676-1460 Ext 115 713-676-1676 Fax kguidry@cesenvironmental.com Date/Time = AUG-01-2008 11:41

Journal No. = 124

Comm. Result = OK

Page(s) = 009

Duration = 00:01:48

File No. = 884

Mode = Memory Transmission

Destination = 18775044474

Received ID = /

Resolution = Fine

-CES ENVIROMENTAL

***** DP-C264 *************** - - ***** - 7137488664- ********



4904 Griggs Road Houston, TX 77021 Tel. (713) 676-1460 Fax. (713) 676-1676

July 16, 2008

To: Farrier Riley From: Ryan Thomas

Dear Mr. Riley,

The purpose of this letter is to inform you that, in the best interest of CES Environmental Services, Inc., your employment is being terminated as of Wednesday July 16, 2008 at 7:00pm.

Please contact the Human Resources Office if you have questions about your benefits or any other matters pertaining to your employment with CES Environmental Services, Inc. You final paycheck will be ready on Friday July 18, 2008. Please be sure to turn in your company cell phone, uniforms and gate pass.

We appreciate all of your hard work and dedication you gave to CES Environmental Services, Inc. and wish you the best in your future.

Sincerely,

Ryan Thomas, Director of Logistics and Customer Service

CES Environmental Services, Inc.



CERTIFIED MAIL RETURN RECEIPT REQUESTED

June 24, 2008

To: Dr. David Dent

(b) (4)

From: Karl Guidry

CES Environmental Services, Inc.

4904 Griggs Rd. Houston, Texas 77021

Re: Workers Comp Claim for Farrier Riley

TEXAS MUTUAL CLAIM

Dear Dr. Dent.

CES Environmental Services, Inc. would like to offer your patient, Farrier Riley a temporary, modified job duty assignment at the CES Environmental Services, Inc facility, located at 4904 Origgs Rd in Houston, Texas. This modified duty position meets the requirements of Rule 129.6 (a) of the Texas Administrative Code.

The schedule for this position is 3:00 pm to 11:00 pm Monday through Friday, and the job pays (4) per hour, which is his current rate of pay. Please determine if the job duties describe below meet the work restrictions which you are willing to certify. Please be advised that as of this date we have received no indication of return to work recommendations from your office nor have we received any work status documentation from you regarding Farrier Riley.

The job involves assisting logistics with coordination of transport vehicles. Mr. Riley's duties will involve sitting at the work station and walking the facility yard to coordinate parking of tankers and rolling stock. This job will not require lifting or driving and we believe is consistent with any treating physician limitations.

While assigned to this modified—duty job position we will only assign tasks that are consistent with Mr. Riley's physical abilities, knowledge and skills. Training will be provided as necessary.



Please indicate if you are willing to certify this temporary, modified job assignment for Farrier Riley.

| I Certify (Sign) | Date 6/25/38 |
|-------------------------|--------------|
| I do not Certify_(Sign) | Date |

Regards,

Karl A. Quidry

CES Environmental Services, Inc.

HSE Manager 4940 Griggs Rd.

Houston, Texas 77021



CERTIFIED MAIL RETURN RECEIPT REQUESTED

June 26, 2008

Accept Faxill Kiley

Farrier Riley Dear Farrier Riley, CES Environmental Services, Inc. would like to offer you a temporary, modified job duty assignment at the facility Tank Wash area, located at 4904 Griggs Rd in Houston, Texas. The schedule for this position is 3:00 pm to 11:00 pm Monday through Friday, and the job pays per hour, which is your current rate of pay. The job duties meet the work restrictions certified by the emergency room physician at St. Luke's Episcopal Hospital, whose work status report is attached. The job involves assisting logistics with coordination of transport vehicles. Your duties will involve sitting at the work station and walking the facility yard. This job will not require lifting and is consistent with the physician limitations. While assigned to this modified –duty job position we will only assign tasks that are consistent with your physical abilities, knowledge and skills. This modified-duty job assignment has been certified by your treating physician, Dr. David Dent, 5409 Bellaire, Bellaire, TX 77401. Training will be provided as necessary. Please contact CES Environmental Services, Inc within 5 days of receipt of this Bona Fide Employment Offer, if you are willing to accept this temporary, modified job assignment. If we do not hear from you within 5 days of your receipt of this notice, we will assyme you are no longer interested in continuing your employment with CES Environmental Services, Inc. /KARL Å. GUIDRY CES Environmental Services, Inc. **HSE Manager**

| Clear Lake Regional Medical Center | Patient Information | Treating Provider | Discharge Instruction |
|--|---|--|---------------------------------------|
| Clear Lake Regional - Pearland Emergency | | 10970 Shadow Creek Ranch Parkway Pearland, TX 77584 | Patient Copy |
| 0970 Shadow Creek Ranch Parkway Pearland, TX 77584 | Phone: | Phone: 713-770-7200 | |
| | | | Page: 1 of |
| Patient Discharge Instructions | | Document: 449 | · · · · · · · · · · · · · · · · · · · |
| | Work Release Form | | |
| This notice verifies that your employee, | iler Dewo | yne Riley | } |
| was seen in this facility on | <u> </u> | <u> </u> | |
| He/sh None: | e may return to work on | 64/08 with the following | restrictions: |
| No he | avy lifting: over | pounds) | |
| No pro | plonged standing: | | |
| Desk | Work Only: | | |
| Other: | | | |
| Restrictions: | | | |
| \bigcirc | | | |
| These restrictions apply through After the | nis date, your employee should | be able to participate fully in all | work duties. |
| NOTE: If symptoms continue and the employee is unab this facility or make an appointment with the referral phy | le to perform the full duties of the sician for further evaluation. | neir job by this date, please advis | se the employee to return to |
| DR. Chu/ KBW | | | |
| Attending MD | | | |
| Discharge Instructions Special Notes | | | |
| I understand that the emergency care which I received is lab studies will be reviewed by appropriate specialists ar | s not intended to be complete a | nd definitive medical care and tr | ealment. EKG"s, X-rays, and |

| Clear Lake Regional Medical Center Clear Lake Regional - Pearland Emer 10970 Shadow Creek Ranch Parkway | Patient Information riley, farrier | | Treating Provider Bobby Chu MD 10970 Shadow Creek Ranch Parkway Pearland, TX 77584 | Discharge Summary Date: 7/1/08 Time: 11:54:14 AM Patient Copy | | | |
|---|---|-------------------|---|--|-------------------------|--|--|
| 77584 | | | | Phone: 713-770-7200 | | | |
| 1) Your Discharge Instructions | ; | | | escriptions: | | | |
| CHRONIC BACK PAIN #Document: | | | | Oral Tablet 50 Milligram 1 TABL | ET DAILY # 4 TABLETS (0 | | |
| BACK EXERCISES #Document: 32 (NARCOTIC MEDICATION #Docume | | | Refills) | -Mat 7 E 20E Milliano 4 TADI | CT CVEDV A TO 6 HOURS | | |
| AAROO TO MEDICATION #DOCUME | nt 540 (English) | | Norco Oral Tablet 7.5-325 Milligram 1 TABLET EVERY 4 TO 6 HOURS | | | | |
| | | | AS NEEDED # 15 TABLETS (0 Refilis) Valium Oral Tablet 5 Milligram 1 TABLET 3 TIMES DAILY # 6 TABLETS | | | | |
| | | | (0 Refills) | | | | |
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| | | | | | | | |
| | | | | | | | |
| 3) You should Follow Up with: | | | | | | | |
| | Follow Up Inform | nation | | | | | |
| | On 07/1/2008 this patient was treated in the Emergency Department at Clear Lake Regional - Pearland | | | | | | |
| | Emergency located a | at 10970 Shadow (| Creek Ranch | Parkway Pearland, TX 77584 f | | | |
| | above. The patient was asked to follow up 2 Days. | | | | | | |
| Phone: | | | | | | | |
| Fax: | | | | | j | | |

Understand that the emergency care which I received is not intended to be complete and definitive medical care and treatment. I acknowledge that I have been instructed to contact the above physician immediately for continued and complete medical diagnosis, care and treatment. EKG's, X-rays, and lab studies will be reviewed by appropriate specialists and I will be notified of significant discrepancies.

I also understand that my signature authorizes this Medical Center to release all or any part of my medical record (including, if applicable, information pertaining to AIDS and/or HIV testing, mental health records, and drug and/or alcohol treatment) to the referred physician listed above.

Clear Lake Regional Medical Center Clear Lake Regional - Pearland Emergency 10970 Shadow Creek Ranch Parkway Pearland, TX 77584 Phone: Patient Information Treating Provider Bobby Chu MD 10970 Shadow Creek Ranch Parkway Pearland, TX 77584 Phone: 713-770-7200 Page: 1 of 1

Patient Discharge Instructions

Document: 77

CHRONIC BACK PAIN

A small number of patients with back injuries have pain that lasts longer than 3 months. A ruptured disc can cause chronic back pain, but half of the time the exact cause cannot be found, even after x-rays and other tests have been done. Arthritis, osteoporosis, tumors, infections, previous back surgery, and other causes may be involved. Anxiety and depression are common factors. A ruptured disc often causes sciatica, a pain traveling from the low back down the back of the leg. This is due to irritation of the sciatic nerve. Surgery is considered only when symptoms do not improve with bed rest and other conservative treatment

Follow These Instructions Carefully:

- 1. You should avoid bending, heavy lifting, prolonged sitting, and activities, which make the problem worse.
- 2. Try to continue with normal activity as much as possible, taking brief periods of rest throughout the day to reduce your pain during bad periods. A back exercise rehabilitation program can be very helpful in reducing symptoms and preventing further episodes of pain.
- 3. Aspinn, ibuprofen, and other anti-inflammatory pain medicine can help control pain, and muscle relaxants are sometimes used.
- 4. Rest and relax your back muscles. Try to find a position of comfort. Lie flat on your back on a firm surface with pillows under your knees; or lie on your side with your knees bent up towards your chest and a pillow between your knees. (If your mattress sags, place a piece of plywood under it or lie on a floor pad for more support.)
 - For severe back pain stay in this position until you are feeling better. Get up only to go to the bathroom or for meals.
 - For less severe back pain, strict bed rest is not needed. However, don't do anything that worsens the pain and avoid prolonged sitting. Be aware of safe bending and lifting methods. Do not lift anything over 15 pounds until all pain is gone.
- 6. <u>Ice packs</u> (crushed or cubed ice in a plastic bag, wrapped in a towel) are best for 20 minutes every 2-4 hours during the first two days after a new injury. <u>Local heat</u> (hot shower, hot bath or heating pad) and <u>massage</u> will help reduce muscle spasm. You can start with ice packs then switch to heat after two days. Some patients feel best alternating treatments. Use the method that feels best to you for.

Follow up with your doctor or this facility if your symptoms do not start to improve after one week. Physical therapy may be needed.

(NOTE: If X-rays were taken, a radiologist will review them. You will be notified of any new findings that may affect your care.)

Return to this facility immediately or contact your doctor if you begin to have any of the following:

- Pain becomes worse
- Marked weakness or numbness in one of your legs.
- You have trouble controlling your bladder or bowels.

Discharge Instructions Special Notes

I understand that the emergency care which I received is not intended to be complete and definitive medical care and treatment. EKG"s, X-rays, and lab studies will be reviewed by appropriate specialists and I will be notified of significant discrepancies.

http://www. Dadath. . . .

| Clear Lake Regional Medical Center | Patient Information | Treating Provider | Discharge Instructions |
|---|---------------------|---|--------------------------------|
| Cledi Lake Regional Medical Center | riley, farrier | Bobby Chu MD | Date: 7/1/08 Time: 11:54:11 AM |
| Clear Lake Regional - Peartand Emergency 10970 Shadow Creek Ranch Parkway Pearland, TX 77584 | Phone: | 10970 Shadow Creek Ranch Parkway Pearland, TX 77584 Phone: 713-770-7200 | Patient Copy |
| | | 1 10,10,17,00 | Page: 1 of 1 |

Patient Discharge Instructions

Document: 548

NARCOTIC MEDICATIONS

You have been prescribed narcotic. Narcotic medicines are used to relieve pain. Some examples of narcotic medicines include the following:

- Codeine (Tylenol #2, #3 cough syrup)
- Propoxyphene (Darvocet, Darvon)
- Hydrocodone (Vicodin)
- Oxycodone (Percocet, Percodan)

This drug may cause drowsiness. Therefore, be sure to take it only as directed.

How To Take This Medication:

- 1. If this medicine makes your stomach upset, take it with food.
- 2. Pain medicine should be taken only if needed at the times prescribed. If you are not having pain, do not take the medicine, unless you are advised to do so by your doctor.
- 3. Narcotic medicines can be habit forming; therefore, take this medicine only as directed. **Do not take** more of it, **do not take** it more often, and **do not take** it for a longer period of time than directed.

What You Should Watch Out For:

Possible Side Effects:

- If you have dizziness, or drowsiness, take a smaller dose, breaking a pill in half or take it less often.
- If you develop constipation, drink lots of liquids, use small doses of a mild laxative like Milk of Magnesia as needed and add fiber to your diet.
- If you have difficulty passing urine, stop taking the medicine and contact your doctor.

Possible Allergic Reactions: Rash, itching, swelling, trouble breathing or swallowing. You should contact your doctor or return to this facility immediately.

Medical Conditions: Before you begin to take this medicine, be sure your doctor knows if you have any of the following conditions:

- Prostate enlargement.
- Pregnancy or breast-feeding.

Possible Drug Interactions: This drug may cause increased side effects when taken with alcohol, muscle relaxant, sedative, tricyclic antidepressants, MAO-inhibitor or another pain medicine. Make sure your doctor knows what other medicines you are taking.

Note These Warnings:

- Do not drive, ride a bicycle, operate dangerous equipment, climb a ladder or do any other activity where you must concentrate and might
 be injured for at least 12 hours after taking this medicine until you know how it will affect you.
- Prolonged use of this medicine can be habit forming and may lead to addiction.
- Tell your doctor what other medicines you are taking.
- Do not drink any alcohol while taking this medicine.

Stop taking this medication and call your doctor or return to this facility right away if you notice any of these problems:

- Hives or itching.
- Confusion, dizziness, or lightheadedness.
- Hallucinations.
- Blurry vision.
- Slow breathing, slow heartbeat, or severe weakness.
- Nausea or vomiting.
- Stomach pain or chest pain.
- Anything else that worries you.

scharge Instructions Special Notes

nderstand that the emergency care which I received is not intended to be complete and definitive medical care and treatment. EKG"s, X-rays, and studies will be reviewed by appropriate specialists and I will be notified of significant discrepancies.



CERTIFIED MAIL RETURN RECEIPT REQUESTED

June 24, 2008

To:

Dr. David Dent

(b) (4)

From: Karl Guidry

CES Environmental Services, Inc.

4904 Griggs Rd. Houston, Texas 77021

Re: Workers Comp Claim for Farrier Riley
TEXAS MUTUAL CLAIM

Dear Dr. Dent.

CES Environmental Services, Inc. would like to offer your patient, Farrier Riley a temporary, modified job duty assignment at the CES Environmental Services, Inc facility, located at 4904 Griggs Rd in Houston, Texas. This modified duty position meets the requirements of Rule 129.5 (a) of the Texas Administrative Code.

The schedule for this position is 3:00 pm to 11:00 pm Monday through Friday, and the job pays (b) (4) the hour, which is his current rate of pay. Please determine if the job duties describe below meet the work restrictions which you are willing to certify. Please be advised that as of this date we have received no indication of return to work recommendations from your office nor have we received any work status documentation from you regarding Farrier Riley.

The job involves assisting logistics with coordination of transport vehicles. Mr. Riley's duties will involve sitting at the work station and walking the facility yard to coordinate parking of tankers and rolling stock. This job will not require lifting or driving and we believe is consistent with any treating physician limitations.

While assigned to this modified—duty job position we will only assign tasks that are consistent with Mr. Riley's physical abilities, knowledge and skills. Training will be provided as necessary.



. Ring, war **2**8 (2038 - 7 37705 - 7 31770) 8337405373 R

Please indicate if you are willing to certify this temporary, modified job assignment for Farrier Riley.

| (Certify_(Sign) | Date 6/ | 25/28 |
|-------------------------|---------|--|
| I do not Certify_(Sign) | Date | некультан материальный мерену невыг причений инференс мены МАС (». Основ Стаймана. |

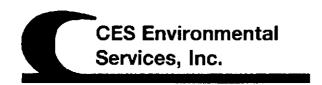
Regards,

Karl A. Guidry

CES Environmental Services, Inc.

HSE Manager 4940 Griggs Rd.

Houston, Texas 77021



4904 Griggs Road Houston, TX 77021 Phone: (713) 676-1460

Fax: (713) 676-1676

Fax

To: Texas Mutual From: Karl Guidry

(b) (4)

Fax: 1-512-224-3889 Pages: 2 Pages to follow

Attn: Workers Comp///ARTHA Date: June 26, 2008

See attached documentation regarding our employee Farrier Riley. It is a letter certifying the approval of the work descriptions in the attached bona fide offer. I have not made this document available to any other party.

Karl Guidry CES Environmental Services, Inc. HSE Manager 4904 Griggs Rd Houston, Texas 777021

713-676-1460 Ext 115 713-676-1676 Fax kquidry@cesenvironmental.com

| No. | Comm. | Pages | File | Duration | X/R | Identification | Date | Time | Diagnostic |
|------------|----------|------------|------------|----------------------|----------------|----------------------|------------------|----------------|--------------------------------|
| 128 | 503 | 005 | 510 | 00:02:28 | XMT | a 7133591124 | JUN-24 | 07:59 | 010FA2000ADC0 |
| 129 | OK | 003/008 | 510 | 00:00:49 | XMT | ā 7133591124 | JUN-24 | 08:05 | 010FA2000ADB0 |
| 130 | OK | 001/001 | 512 | 00:00:27 | XMT | a 2814824066 | JUN-24 | 08:27 | 010FA2000A850 |
| 131 | OK | 001/001 | 513 | 00:00:42 | XMT | a 2819978891 | JUN-24 | 08:28 | 410AA20001070 |
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| 133 | OK | 001/001 | 515 | 00:00:41 | XMT | a 19543084254 | JUN-24 | 08:34 | 010FA2000A070 |
| 134 | Busy | 000/001 | 514 | 00:00:00 | XMT | a 2816817940 | JUN-24 | 08:45 | 0000000000000 |
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| 137 | OK | 002 | 518 | 00:00:41 | XMT | a 12562600053 | JUN-24 | 09:52 | 010FA2000AC60 |
| 138 | OK | 003 | 519 | 00:05:04 | XMT | a 18174266253 | JUN-24 | 10:49 | 010FA2000A010 |
| 139 | OK | 002 | 520 | 00:00:36 | RCV | 7139463213 | JUN-24 | 11:41 | 0507C0000A070 |
| 140 | OK | 021 | 521 | 00:08:16 | \mathtt{XMT} | a 19798489990 | JUN-24 | 11:50 | 01 0FA 2000A070 |
| 141 | OK | 002 | 522 | 00:00:41 | \mathbf{XMT} | a 7137439050 | JUN-24 | 13:24 | 210FA2000BDB0 |
| 142 | OK | 002 | 5 2 3 | 00:00:40 | XMT | a 7137439050 | JUN-24 | 13:26 | 210FA2000BDA0 |
| 143 | OK | 006 | 524 | 00:01:06 | XMT | a 7133162191 | JUN-24 | 14:17 | F10FA2000BCC0 |
| 144 | OK | 001 | 525 | 00:00:19 | RCV | | JUN-24 | 14:27 | 0407C0000BDC0 |
| 145 | OK | 002 | 526 | 00:00:50 | RCV | 7139370146 | JUN-24 | 14:48 | 050FC0000AAB0 |
| 146 | OK | 004 | 527 | 00:01:08 | XMT | a 2818425095 | JUN-24 | 16:02 | 010FA2000BC90 |
| | Stop | 000 | 528 | 00:00:00 | XMT | a 7132396410 | JUN-24 | 16:12 | 0000000000000 |
| | Stop | 000 | 529 | 00:00:00 | XMT | ā 5122396410 | JUN-24 | 16:14 | 0000000000000 |
| 149 | OK | 002 | 530 | 00:00:31 | XMT | a 15122396410 | JUN-24 | 16:15 | E10FA2000BCB0 |
| 150 | OK | 003 | 531 | 00:00:38 | XMT | a 7134758688 | JUN-24 | 16:18 | 010FA2000B890 |
| 151 | OK | 005 | 532 | 00:00:38 | XMT | a 7133162191 | JUN-24 | 16:21 | F10FA2000BCC0 |
| | Stop | 000 | 534 | 00:00:00 | XMT | a 9797986008 | JUN-25 | 07:30 | 0000000000000 |
| 153 | OK OK | 011/011 | 533 | 00:04:19 | XMT | a 19797986008 | JUN-25 | 07:31 | 010FA2000A070 |
| 154 | OK | 011 | 535 | 00:04:17 | XMT | a 19797986008 | JUN-25 | 07:36 | 010FA2000A070 |
| 155 | OK | 001/001 | 536 | 00:01:04 | XMT | □ 7134507421 | JUN-25 | 07:51 | 410FA2000BDB0 |
| 156 157 | OK OK | 012 001 | 537 538 | 00:02:57 | XMT RCV | a 18668083345 | JUN-25 | 08:09 | 010FA2000A070 |
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| 159 | OK | 001/001 | 540 | 00:00:27 | XMT | a 15122396410 | JUN-25 | 10:29 | E10FA2000BC60 |
| 160 | OK | 021 | 541 | 00:00:41 | RCV | A 13122390410 | JUN-25 | 10:29 | 0507C0000ACC0 |
| 161 | 420 | 000 | 542 | 00:04:00 | RCV | | JUN-25 | 11:14 | 0000C00000000 |
| 162 | OK | 002 | 543 | 00:00:35 | XMT | a 18137193861 | JUN-25 | 11:22 | 010FA2000A070 |
| 163 | OK | 001/001 | 544 | 00:00:03 | XMT | ā 12102819731 | JUN-25 | 12:47 | 010FA2000A070 |
| 164 | OK | 017 | 545 | 00:04:31 | TMX | ā 13377435084 | JUN-25 | 13:34 | 000FA2000ADA0 |
| 165 | 420 | 000 | 546 | 00:00:38 | RCV | 2 10077100001 | JUN-25 | 14:22 | 0000C00000000 |
| 166 | OK | 001 | 547 | 00:00:18 | RCV | | JUN-25 | 14:27 | 0407C0000BDC0 |
| 167 | OK | 003 | 548 | 00:01:00 | RCV | 7137280834 | JUN-25 | 14:55 | 0507C0000A070 |
| 168 | OK | 002 | 549 | 00:00:38 | XMT | □ 18137193861 | JUN-25 | 16:15 | 010FA2000A070 |
| 169 | OK | 003 | 550 | 00:00:42 | XMT | a 7136758803 | JUN-25 | 16:31 | 410FA2000BCB0 |
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| 172 | ΟŘ | 001/001 | 553 | 00:00:54 | XMT | Ճ 7139214466 | JUN-26 | 09:41 | 000FA2000A070 |
| 173 | OK | 005 | 555 | 00:00:49 | XMT | a 2814573232 | JUN-26 | 09:56 | 010FA2000BC80 |
| 174 | OK | 001/001 | 556 | 00:00:55 | TMX | Ճ 7137950949 | JUN-26 | 10:00 | 010FA2000ADB0 |
| 175 | OK | 003 | 557 | 00:00:50 | TMX | ā 15122243889 | JUN-26 | 10:03 | F00FA2000BC60 |
| | Busy | 000/002 | 554 | 00:00:00 | TMX | Ճ 2818425095 | JUN-26 | 10:07 | 0000000000000 |
| 177 | OK | 001/001 | 558 | 00:01:05 | TMX | 5 7137950949 | JUN-26 | 10:10 | 010FA2000ADA0 |
| | | | | | | | | | |

***** DP-C264 ************** - - ***** - 7137488664- *******

-CES ENVIROMENTAL -



CERTIFIED MAIL RETURN RECEIPT REQUESTED

June 24, 2008

To: Dr. David Dent

(b) (4)

From: Karl Guidry

CES Environmental Services, Inc.

4904 Griggs Rd. Houston, Texas 77021

Re: Workers Comp Claim for Farrier Riley

TEXAS MUTUAL CLAIM

Dear Dr. Dent

CES Environmental Services, Inc. would like to offer your patient, Farrier Riley a temporary, modified job duty assignment at the CES Environmental Services, Inc facility, located at 4904 Griggs Rd in Houston, Texas. This modified duty position meets the requirements of Rule 129.6 (a) of the Texas Administrative Code.

The schedule for this position is 3:00 pm to 11:00 pm Monday through Friday, and the job pays ber hour, which is his current rate of pay. Please determine if the job duties describe below meet the work restrictions which you are willing to certify. Please be advised that as of this date we have received no indication of return to work recommendations from your office nor have we received any work status documentation from you regarding Farrier Riley.

The job involves assisting logistics with coordination of transport vehicles. Mr. Riley's duties will involve sitting at the work station and walking the facility yard to coordinate parking of tankers and rolling stock. This job will not require lifting or driving and we believe is consistent with any treating physician limitations.

While assigned to this modified—duty job position we will only assign tasks that are consistent with Mr. Riley's physical abilities, knowledge and skills. Training will be provided as necessary.

Please indicate if you are willing to certify this temporary, modified job assignment for Farrier Riley.

| I Certify_(Sign) | Date 6/25/38 |
|-------------------------|--------------|
| I do not Certify (Sign) | Date |

Regards,

Karl A. Guidry

CES Environmental Services, Inc.

HSE Manager 4940 Griggs Rd.

Houston, Texas 77021



12600 N, Featherwood, Suite 200 Houston, Texas 77034-4440 Phone: (713) 223-1234 Fax: (713) 910-9010 Mail@OgletreeAbbott.com

BILL OGLETREE BILL ABBOTT CELINA RECALDE FYODOR CLAY BIANCA MARTINEZ LESLIE LEVINGSTON ADRIENNE GASSER ENRIQUE VARELA

TELEFAX COVER SHEET

From Fax Number: (713) 910-9010

If you experience any problems with the quality of our transmission, please call (713) 223-1234

CONFIDENTIALITY NOTICE

This fax and any attachments are confidential and may be protected by legal privilege. If you are not the intended recipient, be aware that any disclosure, copying, distribution or use of this fax or any attachment is prohibited. In such case, you should destroy this fax and kindly notify the sender. Please advise immediately if you or your employer do not consent to faxes of this kind. Opinions, conclusions and other information in this fax that does not relate to the official business of my firm shall be understood as neither given nor endorsed by it.

This fax does not create nor is it intended to create an attorney/client relationship.

PAGES SENT:

, pages including this cover page

TO

Karl A. Guidry, HSE Manager

COMPANY

CES Environmental

FAX NO

713-676-1676

FROM

Fyodor Clay

DATE

June 22, 2008

RE

Farrier Riley

MESSAGE

We represent the above named employee in connection with his Workers' Compensation claim. I am in receipt of what

the employer purports to be a "Bona Fide Offer of

Employment." (See Exhibit A). After careful review it has come to my attention that it does not meet the requirements set forth in Rule 129.6 of the Texas Administrative Code,

therefore rending it invalid.



BILL OGLETREE BILL ABBOTT LISA SECHELSKI CELINA RAMIREZ 12600 N. Featherwood, Suite 200 Houston, Texas 77034-4440 Phone: (713) 223-1234 Fax: (713) 910-9010 Mail@OgletreeLawFirm.com

> FYODOR CLAY LAURA RODRIGUEZ BIANCA MARTINEZ JACQUELYN COLEMAN

June 22, 2008

CES Environmental

Attention: Yvonne L. Medelez

4904 Griggs Rd. Houston, TX 77021

Re:

Our Client:

SSN:

Date of Injury:

Claim No.:

DWC No.:

Farrier Riley
(b) (4)
May 22, 2008

(b) (4) 08272108-MI

Dear Sir or Madam:

We represent the above named employee in connection with his Workers' Compensation claim. I am in receipt of what the employer purports to be a "Bona Fide Offer of Employment." (See Exhibit A). After careful review it has come to my attention that it does not meet the requirements set forth in Rule 129.6 of the Texas Administrative Code, therefore rending it invalid.

An employer may offer an employee a modified duty position, which has restricted duties which are within the employee's work abilities as determined by the employee's <u>treating doctor</u>. In the <u>absence</u> of a Work Status Report by the treating doctor an offer of employment may be made based on another doctor's assessment of the employee's work status provided that the treating doctor has not indicated disagreement with the restrictions identified by the other doctor. To the best of my knowledge, the Claimant's treating doctor has the clamant off work. It is the Claimant's treating doctor who determines work restrictions. APPEAL 061195 – JULY 28, 2006.

According to Rule 129.6(b), it is only in the absence of a DWC-73 by the treating doctor that an offer of work may be made based on another doctor's DWC-73. A further restriction is that the treating doctor has not indicated disagreement with the other doctor's restrictions. APPEAL 071650 - NOVEMBER 12, 2007.

Per Rule 129.6 (a) of the Texas Administrative Code:

(a) An employer or insurance carrier (carrier) may request the treating doctor provide a Work Status Report by providing the treating doctor a set of functional job descriptions which list modified duty positions which the employer has available for the injured employee (employee) to work. The functional job descriptions must include descriptions of the physical and time requirements of the positions.

Per Rule 129.6 (b) of the Texas Administrative Code:

(b) An employer may offer an employee a modified duty position, which has restricted duties, which are within the employee's work abilities as determined by the employee's treating doctor. In the absence of a Work Status Report by the treating doctor an offer of employment may be made based on another doctor's assessment of the employee's work status provided that the doctor made the assessment based on an actual physical examination of the employee performed by that doctor and provided that the treating doctor has not indicated disagreement with the restrictions identified by the other doctor.

Rule 129.6 (c) of the Texas Administrative Code states:

An employer's offer of modified duty shall be made to the employee in writing and in the form and manner prescribed by the Commission. A copy of the Work Status Report on which the offer is being based on shall be included with the offer as well as the following information:

- (1) the location at which the employee will be working
- (2) the schedule the employee will be working;
- (3) the wages the employee will be paid;
- (4) a description of the physical and time requirements that the position will entail; and
- (5) a statement that the employer will only assign tasks consistent with the employee's physical abilities, knowledge, and skills and will provide training if necessary

To reiterate, please forward what the employer purports to be a "Bona Fide Offer of Employment" to the employee's <u>treating doctor</u>. Please make sure it meets the requirements set forth in Rule 129.6 of the Texas Administrative Code.

Claimant's Treating Doctor: 713-660-9123 Dr. David Dent 5409 Bellaire Bellaire, TX 77401 I can be reached via e-mail at <u>Fyodor.Clav@ogletreeabbott.com</u> or via telephone at the number listed above, ext 128. Thank you for your attention to this matter.

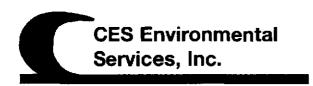
Sincerely



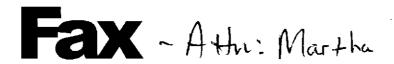
CEDTIFIED MAII

| RETURN RECEIPT REQUESTED | |
|---|---|
| June 18, 2008 | |
| Farrier Riley (b) (4) | |
| TEXAS MUTUAL CLAIM | |
| Dear Farrier Riley, CES Environmental Services, Inc. would like to offer you a temporary, mod assignment at the facility Tank Wash area, located at 4904 Griggs Rd in Hot The schedule for this position is 3:00 pm to 11:00 pm Monday through Frida job pays thour, which is your current rate of pay. The job duties restrictions certified by the emergency room physician at St. Luke's Episcop whose work status report is attached. | iston, Texas. By, and the neet the work |
| The job involves assisting logistics with coordination of transport vehicles. will involve sitting at the work station and walking the facility yard. This jo require lifting and is consistent with the physician limitations. | |
| While assigned to this modified -duty job position we will only assign tasks consistent with your physical abilities, knowledge and skills. Training will tas necessary. | |
| Please contact me as soon as possible if you are willing to accept this tempor modified job assignment. KARL A. GUIDRY CES Environmental Services, Inc. HSE Manager | mry, |
| Enclosed: TWC Work Status Report | |
| AcceptDate | |
| Decline Date | |





4904 Griggs Road Houston, TX 77021 Phone: (713) 676-1460 Fax: (713) 676-1676



To: Texas Mutual From: Karl Guidry

(b) (4)

Fax: 1=512-224-3889 | All Pages: Pages to follow

713-3(6-719)

Attn: Workers Comp Date: June 4, 2008

See attached documentation regarding our employee Farrier Riley.

Karl Guidry CES Environmental Services, Inc. HSE Manager 4904 Griggs Rd Houston, Texas 777021

713-676-1460 Ext 115 713-676-1676 Fax kguidry@cesenvironmental.com ****** Date JUN-09-2008 **** Time 14:30 ******

Date/Time = JUN-09-2008 14:20

Journal No. = 130

Comm. Result = OK

Page(s) = 013

Duration = 00:03:13

File No. = 314

Mode = Memory Transmission

Destination = 7133162191

Received ID = / 7133162191

Resolution = Fine

-CES ENVIROMENTAL -

***** DP-C264 **************

- ***** - 7137488664- *******

Serid the specified copies to your Workers' Compensation Insurance Carrier and the injured employee.

*Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, Unless the Division specifically requests a direct filling.

| | ~ | | | |
|--------|---|-----|------|------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| CLAIM# | | ··· | | |

| | CARRIER'S CLAIM# |
|---|---|
| EMPLOYERS FIRST REPO | RT OF INJURY OR ILLNESS |
| i. Name (Last, First, M.I.) | 15. Date of Injury (m-d-y) 16. Time of Injury 17. Date Lost Time Began |
| Tiley | 5-21-8 4 15 am pm \$ 5 24 08 |
| (b) (4) | 18. Nature of Injury* 19. Part of Body Injured or Exposed* |
| (5) (4) | Pincho Nerve BACK |
| 5. Doos the Employee Speak English? If No. Speatly Language | 20. How and Why Injury/Illness Occurred* |
| YES NO D | SEE Attached Incident Report |
| 7. Race White 8. Ethnicity Hispanic | 21. Was employee 22. Worksite Location of Injury (stairs, dock, etc.)* |
| Black Asian Native American Other | regular job? NO ENTRY CATE |
| 1 4 Malling Address Street of P.O. Box | 23. Address Whore trium or Eveneura Openford Name of huniness if incident |
| (b) (4) | occurred on a business site |
| Utto VA | occurred on a business site, 1002 N. Richey, PASA Deva, IX 77506 Street or P.O. Box |
| (b) (4) | HAMPELS |
| 10. Mantal Status | City Code State Zip Code |
| Married Widowed Separated Single Divorced 11. Number of Dependent Children 12. Spouse's Name | 24. Cause of Injury(fall, tool, machine, etc.)* |
| | 1 . |
| 13. Doctor's Name + Luxes Hospital ER | MA Chure 25. List Witnesses |
| St Lukes Hospital ER | Sec Attache Locident Report |
| 14. Doctor's Mailing Address (Street or P.O.Bex) | 26. Return to work 27. Did employee 28. Supervisor's 29. Date Reported date/or expected die? Name (m-d-y) |
| 6720 Bertner Avenue | (m-d-y) |
| City State Zip Code | 6 17-08 YES NO THOMAS 5 22.08 |
| Houston IX 77325 | 6 17-08 Thomas 5 22.08 |
| | |
| 30. Date of Hire (m-d-y) 31. Was employee hired or recruited in Texas? | 32. Length of Service in Current Position 33. Length of Service in Occupation |
| YES NO - | Months 2 Years Months 2 Years |
| 34. Employee Payroll Classification Code 35. Occupation of Injured V | Vorker |
| DRIVER 36 Rate of Pay at this Job 37. Full Work Week is: | T 00 1-12 2 |
| (b) | 38. Last Paycheck was: 39. Is employee an Owner, Partner, or Corporate Officer? |
| Hourly Weekly 40 Hours 5 Days | st. B for 6.2 Hours or Days YES NO |
| 40. Name and Title of Person Completing Form | 41 Name of Business |
| KARL A. GUNDY HSE MANAGER | CES ENVIRONMENTAL SERVICES |
| 42. Business Mailing Address and Telephone Number Street or P.O. Box. Telephone | 43. Business Location (If different from mailing address) |
| 4904 GTUGGS PO (7/3) 676-1460 | Number and Street RD |
| City State Zip Code | City State Zip Code |
| Houston X 77031 | Houston 1x 77021 |
| 44. Federal Tax Identification Number 45. Primary North American Industry Classific Code: (6 digit) | cation System 46. Specific NAICS Code 47. Texas Comptroller Taxpayer No. (6 digit) |
| 1003-10-123 | |
| 48. Workers' Compensation Insurance Company TEXAS Mulhan [| 49. Palicy Number 2001086044 |
| 50. Did you request accident prevention services in past 12 months? | 0001016044 |
| YES O NO THE YES O NO THE YES NO THE YES ON YES ON | |
| 51. Signature and Title READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIG | GNING) |
| X Kul A. Awdry HSE MANAGER | Date 6-4-8 |

DWC FORM-1 (Rev. 10/05) Page 3



DIVISION OF WORKERS' COMPENSATION



| CLAIM# | |
|-----------|--|
| Carrier # | |
| | |

SUPPLEMENTAL REPORT OF INJURY

| Part I EMPLOYER INFORMATION | 1 | | | |
|--|----------------------------------|------------------------------|---------------------------------------|--------------------------|
| Employer business name | 1.1 Convers | | 2. Employer phone # | 1 & |
| 3. Employer mailing address | HAL SERVICES | | 713-676-14 | <u> </u> |
| | D. Houston, | TX 77621 | | |
| 4. Insurance carrier name | o. Housian | 171 11601 | | |
| IEXAS Mutual | | <u></u> | | |
| Does the employer have return to work (If so, identify contact person a | | based on the injured work | er's current capabilities? y | es no |
| 6. Has the insurance carrier provided RTW | coordination services within the | ne past 12 months? yes | Date | no |
| 7. Has the employer requested RTW training | g from DWC or the insurance | carrier? yes | | na 🔽 |
| 8. Has the insurance carrier provided accide | ent prevention services in the | past 12 months? yes | Date | no 🔽 |
| Hais the employer requested accident pre | vention services from the ins | urance carrier? yes | | no 🚺 |
| Part II REASON FOR FILING THIS | REPORT (deadlines | vary, see instruction |)s) | |
| 10. a. The injured worker returned t | | | • | |
| b. The injured worker is earning | | | | |
| c. The injured worker returned, | | · | • • | within 3 days. |
| Part III INJURED WORKER INFOR | | yment: File within 10 days | · · · · · · · · · · · · · · · · · · · | |
| 11. Injured worker name. | TIME | 12. SSN (last 4 digits) | 13. | DOI |
| FARRIER KILLY | | xxx-xx- b) (4 | 5-6 |) } } } } |
| 14 Injured worker mailing address and phore (b) (4) | e# | | | |
| 15. First day or lost time or reduced | | To. First day or additional | ar jost time | |
| wages for this injury (mm/dd/yyyy) 5 | -23-08 | or reduced wages (r | | -08 |
| 17, Has the injured worker experienced 8 da | | _ | t of the injury? y | es 🔽 no 🗀 |
| If yes, the date of the 8th day (mm/dd/yyy | V) JUNE 1, 24 | <u> </u> | | |
| 18. Date of most recent RTW 5-34-08 | 19. Has the injured worker | resigned, been terminated | or died? y | es no |
| Full duty, full pay | date of resignation | date of termination | n date of | death |
| Limited duty, full pay | 19a. Reason for resignation | termination (| | |
| Limited duty, reduced pay | 19b. Was the injured worker | on limited duty when term | inated? ye | s 🔲 no 🔲 |
| 20. Hours the injured worker was working du | ring the pay period of | 21. Weekly/hourly earni | ngs for the pay period of | |
| 5-22-08 to 6-4-08: | hours per week | to : \$ | weekly or | \$ |
| Indicated hours are: | | Indicated wages are: | | |
| Increase from pre-injury | | Increase f | rom pre-injury wage | |
| Same as pre-injury | | · == - | e-injury wage | |
| Decrease from pre-injury | | | from pre-injury wage | |
| This form to be filed with: The employ | er's insurance carrier and t | he injured worker in the | timeframe as noted in Pa | ort //. |
| 22. To the best of my knowledge the inform | ation provided in this report is | accurate and may be relie | d upon for evaluation of e | ligibility for benefits. |
| Subpritted by: | nployer Injured V | Vorker (If no langer warking | g for the employer where in | njury occurred.) |
| VIII | E 1/1. | , | | |
| 40-14. Numby H3/ | = MAnager | 6- | 4-08 | |
| Signature and Title of person completing this for | | Dale | | |

DWC FORM-6 (Rev. 10/05) Page I

DIVISION OF WORKERS' COMPENSATION

Employee - You are required to report your injury to your employer within 30 days if your employer has workers' compensation insurance. You have the right to free assistance from the Texas Department of insurance, Division of Workers' Compensation and may be entitled to certain medical and income benefits. For further information call your local Division field office or 1 (800)-252-7031.

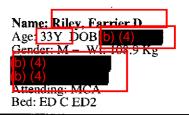


Empleado - Es necesario que reporte su lesión a su empleador dentro de 30 días a pertir de la facha en que se tesionó si es que su empleador cuenta con un seguro de compensación pera trabajadores. Used tiene derecho a recibir asistencia grativa por pane de la División de Compensación para Trebejadores, y también puede tener derecho a ciertos beneficios médicos y monetarios. Para mayor información comuniquese con la oficina local de la División al teléfono 1-800-252-7031.

 ρ . I

| | RS' COMPENSATION WORK ST | ATUS REPORT |
|---|--|---|
| PART I: GENERAL INFORMATION | Dodor's Name and Degrae VI VNES)- Parsons Off | or transmission purposes only) Date Being Sent |
| 2. Date of Injury 5-22-08 (b) (4) 4. Employae's Description of Injury/Agaident 1 Me Between Gate | Procity Name Pemiley (Niv) Practic. Clinic/Fackty/Doctor Phona & Fax Thric/Fackty/Doctor Address (street address) TO 18 Co. N. Pacway | D. Employer's Name (1) I'V OMEN SC D. Employer's Fax N or Email Address (if known) 1. Insurance Carrier 21. Carrier's Fax N or Email Address (if known) |
| (c) will allow the employee to return to work a through (date). | | tified in PART III, which are expected to last tel and is expected to continue through |
| PART III: ACTIVITY RESTRICTIONS* (ONL) 14. POSTURE RESTRICTIONS (If any): | COMPLETE IF BOX 13(b) IS CHECKED) 17. MOTION RESTRICTIONS (if any): | 19. MISC. RESTRICTIONS (if any): |
| Max Hours per day: 0 2 4 6 8 Other Standing | Max Hours per day: 0 2 4 6 8 Other Walking | Max hours per day of work: Sit/Stretch breaks of |
| PART IV: TREATMENT/FOLLOW-UP APPO | NINTMENT INFORMATION | |
| 21. Work Injury Diagnosis Information: 22. E. F. F. F. F. F. F. F. F. F. F. F. F. F. | spected Follow-up Services Include: | on (date) at : am/pm At this time, no further medical care is anticipated. Role of Doctor: Treating doctor Designated doctor Referral doctor |
| DWC FORM-73 (Rev. 10/05) Page I | | DIVISION OF WORKERS' COMPENSATION |

ST LUKES DISCHARGE INSTRUCTIONS



It is important you read and follow the discharge instructions below carefully. If your symptoms change, become worse, or you develop new symptoms that cause concern, call your doctor or return to the Emergency Department or a Community Emergency Center.

POLLOWUP CONTACTS

SPECIAL INSTRUCTIONS

Follow-up with your doctor in 24-48 hours if not improving.

Otherwise, see your doctor next week.

Have your doctor review all results + records from your ER evaluation/treatment

Return if symptoms worsen.

MEDICAL INSTRUCTIONS

BACK PAIN & INJURY-EI

HYPERTENSION

PRESCRIPTIONS

Vicodin: Tablet: 500 Mg-5 Mg: Oral

Dispense: 20, Quantity: 1-2, Schedule: Every 4 to 6 hours

If you were directed to follow-up with your doctor or a specialist, hake your appointment as soon as possible. When calling for your appointment, let the office know you were referred after an emergency department visit.

After going home if you feel unsafe, and you may hurt yourself or others, call 911 or go to the nearest Emergency Department.

SUPPORT AND HELP BY PHONE:

Suicide Prevention Lifeline (800) 273-TALK (8255) Council on Alcohol and Drugs Houston (713) 942-4100

Poison Control Center (800) 222-1222

Can we help you find the doctor that's right for you? Call the:

ST. LUKE'S Physician Referral Line (832) 355-4343

Kelsey-Seybold Clinic

(713) 442–0000 (may call 24 hours a day)

St. Luke's Emergency Services

Main Emergency Department: 832-355-2121

Community Emergency Center Holcombe: 832–355–7525 Community Emergency Center San Felipe: 713–267–7100

COMING SOON! Community Emergency Center Pearland - SUMMER 2008

www.stlukestexas.com

Prepared: Thu May 29 2008 15:51 by MCA 1 of 1 Copyright 2006. Picis.

DWC FORM-6 Supplemental Report of Injury

DWC requires the reporting of all Return to Work and Post-Injury Change of Earnings. An injured worker is entitled to temporary income benefits if he/she has disability (defined as the inability to work, or the inability to earn wages equivalent to pre-injury wages, as a result of the injury) and has not reached maximum medical improvement (defined as having reached 104 weeks from the eighth day of lost time or when a doctor certifies that no further recovery can be reasonably anticipated). The insurance carrier shall adjust the weekly amount of temporary income benefits paid to the injured worker to match the fluctuations in weekly earnings after the injury. To ensure the insurance carrier has accurate information to calculate benefits, the DWC FORM-6 is to be completed as applicable:

| By EMPLOYER | By INJURED WORKER |
|--|---|
| The EMPLOYER means the employer for whom the injured worker was working when the injury occurred. If the employer is the current employer, then you are responsible to provide information to the workers' compensation insurance carrier about: The existence of earnings, and Any offers of employment. Include CLAIM and insurance carrier numbers in right upper hand corner. Complete items 1-21, sign and date. | If you (the INJURED WORKER) are no longer employed by the employer where the injury/illness occurred, then you are responsible to provide information to the workers' compensation insurance carrier about: The existence of earnings, and The amount of any earnings, or Any offers of employment. This form may be used to do so. Include CLAIM and insurance carrier numbers in right upper hand corner. Complete items 1-4, 10-21, sign and date. |
| The EMPLOYER must file this form: For a worker's injury/illness that occurs after January 1, 1991 and required the previous filing of a DWC FORM-1, Employer's First Report of Injury; and During the time the injured worker is entitled to temporary income benefits (TIBs); and Until the injured worker: Reaches maximum medical improvement (MMI), or Is no longer employed by the employer. | If you are employed by a new employer after the injury; and You are receiving benefits, you must tell the insurance carrier if your wages change, regardless of whether your income went up or down; or You are not receiving benefits, you must tell the insurance carrier if the injury causes you to miss work or lose income. |

This report must be filed in the following situations within the timeframes indicated:

- 3 days after the injured worker begins to lose time from work as a result of the injury, if lost time did not occur immediately following the injury;
- 3 days after the injured worker returns to work;
- 3 days, when the injured worker returned to work, then later has additional day(s) of lost time as a result of the injury;
- 10 days after the end of each pay period in which the injured worker has a change in earnings as a result of the injury;
- 10 days after the injured worker resigns or is terminated.

While most of the sections on this form are self-explanatory, please note that the pay periods requested in sections 20 & 21 may be different depending on the situation for which the form is being filed:

- If the report is indicating lost time from work or the end of employment, the pay period shall be the most recent pay period prior to the lost time.
- If the report is indicating return to work or a change in earnings, the pay period shall be the pay period the injured worker is heginning.

This form is to be filed by first class mail or personal delivery with:

- The insurance carrier, and
- · The injured worker.

This report is considered filed when personally delivered or postmarked.

This form is to be filed by first class mail or personal delivery with:

· The insurance carrier.

This report is considered filed when personally delivered or postmarked.

If you return to work for the same employer or a different employer, your temporary income benefits from the insurance carrier must be adjusted.

Failure to report earned wages and/or offers of employment to the insurance carrier who is paying benefits to you is a crime that may result in fines and/or imprisonment.

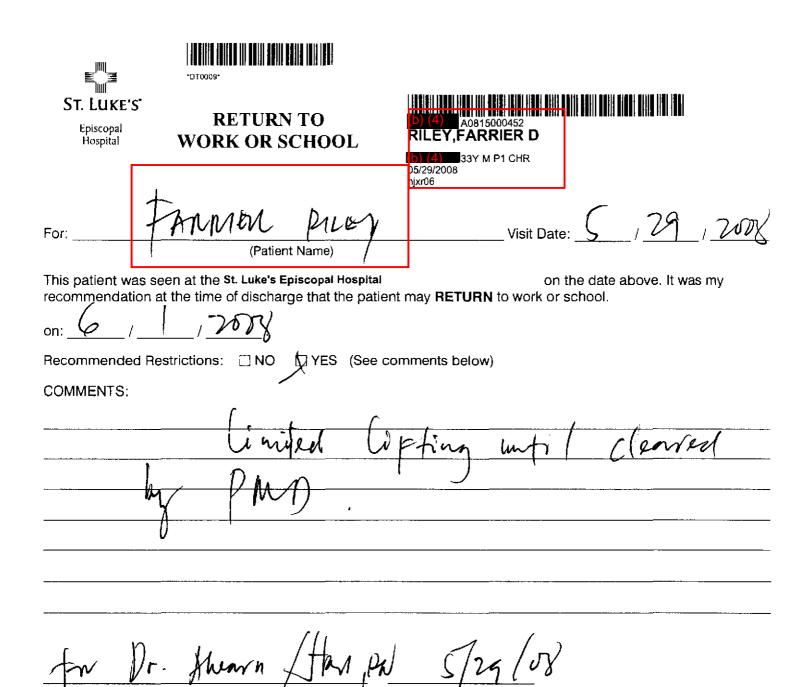
Failure to comply with these filing requirements, without good cause, is a Class D administrative violation, subject to a penalty not to exceed \$500.

TLC§ 409.005 and Rules 120.3 and 129.4 provide the requirements regarding use of this report. The complete rule text is available on the DWC website at: www.tdi.state.tx.us



DWC FORM-6 (Rev. 10/05) Page 2

DIVISION OF WORKERS' COMPENSATION



Return to work/school letter valid for this visit only

For additional time beyond date stated above, please contact Primary Care Doctor for follow-up appointment

6720 Bertner Avenue

Houston, TX 77225-0269

713-785-8537



GULF COAST WASTE DISPOSAL AUTHORITY

WASHBURN TUNNEL FACILITY 1002 N. RICHEY PASADENA, TX 77506-1041

| Chris @ CES Transport | | |
|-----------------------|-------|--|
| | | |
| 713 676 1676 | | - |
| Clark Wolfe @ G.C.A. | | |
| 5-22-08 | | |
| Accident Report for S | -22-0 | 2 |
| 4 | | |
| | | |
| | | Clark Wolfe @ G.C.A. 5-22-08 Accident Report for 5-22-09 |

CONFIDENTIALITY NOTICE

The documents accompanying this facsimile transmission may contain confidential information which is privileged. The information is intended to be reviewed initially by only the individuals named above. If you have received this facsimile in error, please immediately notify this office by telephone to arrange for the return of the original documents to us at our expense. You are hereby notified that any disclosure, copying, distribution or the taking of any action in reliance on the contents of this facsimile is strictly prohibited.

Confidential Report

Section 1. Please print or type in all information. Please use black ink only. This report must be completed within 24 hours of the Illness/Injury/Incident and forwarded to the Human Resources Department.

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|---|-----------------|-----------------------|-------------|---------|-----------|------------|--|---------------------------|-------------|---------------------------------------|
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| Home Address | | | | | | | Ciry | ' | | State |
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| Date of this | T Companie | | | | · Aloni | | te of Incident | Time of Incide | <u> </u> | T A T |
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| | 6 | Years | ч | Mon | he | <u>ا ح</u> | - 22-08 | 4:15 0 | 444 10 | Reported 5-12-0 |
| Employee was Working | | Employment | Category | | 413 | 17 | Phase of Empl | oyee's Workday | Alvi (S) Fr | (Chairman |
| CitibioAsc Maz MotKii | 3 | Ciribidalitetir | Category | | | j | Filase of Entipe | oyees avoiday | at time c | n injury |
| ☑ Alone | | Regular, | full-time | \Box | Contrac | , | ☐ Performing | Mark Durine | | During Break Period |
| With fellow workers | | Regular, | nad-lime | ٦ì | emaar | `n | | leaving the Build | | During Meal Period |
| Other | | ☐ Non-emp | | υ, | Ciripon | -''7 | Other | caving the out | ınıg. | ☐ Working Overtime |
| | | | , | | | j | | *** | | C -volking overtime |
| Specific Location of Inc | cident | | | | | | | | | Was it on the |
| Office | | Elevator | | | .ab | | | Press Building | | Employer's Premises? |
| Restroom | | Lobby | | _ | Vareho | use | | Storage Buildin | <u>.</u> | emproyer a ciermaca: |
| Parking Area | |) Office Grounds | 5. | | ift Stati | | | Blower Room | 7 | ☑ Yes □ No |
| Hallway | | Meeting Room | | | Aeration | | | Disinfection Are | a | |
| Sidewalk | | Vehicle | | | Claritier | | _ | Other Front | | |
| Photocopy Room | | Tank Farm | | | ond # | | _ | - 11.01 <u>- 1101 - 1</u> | | |
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| ☐ No apparent Injury | Ė | Medical Treats | ment | | l □ Da | 3vs av | way from work # | | | ☐ Hospital |
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| Lost Work Days | Ē | Other | | | נס 📋 🏻 | ite re | ed work days # turned to work | / / | | . Doctor |
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| Name and Address of | Treating F | ^a hysician | | | | Nam | e and Address o | f Hospital | | |
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GCA Accident and Near Miss Report

Confidential Report, page 2

| Witness Statement (if applicable |) If more than one withes | is, alta | ch a separat | e sheet. | - | | *************************************** |
|--|--|---|---------------------------------|--|--------------------------------|--|--|
| Witness Signature and Date | | 1 | | | ²hone # | | |
| Section 2To be completed in Supervisor's Description of Incide | | or Sat | fety Coordin | ator | | | |
| Supervisor's Name and Signatur | e and Date Ches | t | el 5. | emen | Witnes | sed Incident? | Yes 1746 |
| What condition of jools Equipate Mazardous Placement Hazardous Placement Floors/Work Space Inadequate Ventilation Humination Equipment Failure Inadequate Housekeeping | ment of Work Area Go | /Barrie uip/Veh ation De er PPE ongesti | rs Nicle esign | Mnarcatised of Influe Abuse or Misuse Inadequate Mainten: Lack of Knowledgo/ Inadequate Supervis Inadequate Tools/Ed | ance Training | iandarti:@oralitic Not:Applicable 2 Improper Wor Inadequate S Defective Too Illumination Inadequate/In | k Surfaces uards/Barriers ols/Equip/Vehicle |
| What action et inaction dontrif Failure to Make Secure Used Equipment Improperly Improper Loading Improper Technique Failure to Warn/Signal Used Defective Equipment Improper Lifting Unauthorized Actions Improper Position Horseptsy/Distractive Action | outed to the incident? Not Applicable to the influence on the procedure of the procedure of the incident of t | ugs/Ald re Devi g Equip cling ir quipm er PPE per Spa | ohol ation ment n Haste cnt Use | Improve Enforcement Improve Enforcement Improve Enforcement Improve Period Improve Design/Cor Improve Illumination Re-instruction of Employed Improve Ventilation Corrective Counseling Eliminate Congestion Eliminate Congestion Improve Ventilation Eliminate Congestion Improve Ventilation Eliminate Congestion Improve Ventilation Improve Vent | nt Ipment E estruction eployee | ☐ Task Analysis ☐ Use Other Me ☐ Install/Rovise ☐ Reassign Job ☐ Mandatory Pr ☐ Improve/Chal ☐ Task Analysis ☐ Improve Store | s to Be Completed aterials/Supplies Guards/Devices |
| Specific Corrective Actions or Corrective Action Taken | Preventative Measures | Takei | Porson Re | | | arget Date | Date Completed |
| Supervisor' Signature | *** | Date | | Manager's Signature | | A 0.107 | Date |
| Safety Coordinator Signature | | Date | • | Received in HR by | | · · | Date |

Favier Riley

I pulled up to sate went to front Office it was locked noone was inside. As I was about to set into truck someone was pulling out of plan I Stood outside of truck to ask if I was at the right place as me and the guy who stop to will help were looking at my paper work. The gate begain to close before I could react I was in between the gate and the truck as the truck pulled away the gate pushed me into the truck and I rolled off the truck with gate in hand and when it slipped off

track that's when it stopped. The gate made cuts and tore off clothes_

1625

Refuse medical Care from Dr. or Hospital, Cleanes cut on left rist, small cut on right arm cleared and did medical treatment, some brushing on right side of Chest, under liest area.

Cheste & Semien Witness Clark Wafe

1710 - Driver Came back said he do wont to go to hospital, get x-rays of Chest.

Che

Section I. Please print or type in all information. Please use black ink only. This report must be completed within 24 hours of the Illness/Injury/Incident and forwarded to the Human Resources Department.

| Home Address (b) (4) County or Residence b) (4) Date of Hire expe | ☐ Divorced ☐ | | Spouse's | Emp | City Signification | i FE | <u> </u> | Number of Depender Children State |
|---|------------------------------|-----------------|-------------------|---------------|--------------------|------------------------------------|--------------|---------------------------------------|
| Single Married Home Address (a) (4) County or Residence (b) (4) County or Residence (c) (4) County or Residence (d) County or Residence (d) County or Residence (d) County or Residence (d) County or Residence (d) County or Residence (d) County or Residence (d) County or Residence (d) County or Residence (d) County or Residence (d) County or Residence (d) County or Residence (d) | Prione Hence in Occupa | | Spouse's | Emp | City S#n/7 |) <i>FE</i> | | Children |
| ounty or Residence) (4) are of File Expe (4) Imployee was Working 3 Alone With fellow workers | inches in Occupa | ition at 1 ime | | _ | Sann | r <i>FE</i> | Facility | 1 |
| ate of File Expe (4) The property of the control | inches in Occupa | nton at 1 me | | _ | Sănī7 | <i>FE</i> | Facility | Texas |
| (4) Imployee was Working Alone With fellow workers | inches in Occupa | icon at Time | | _ | loyee's Occupa | tion | Facility | |
| (4) Imployee was Working Alone With fellow workers | /O Years | Mon at time | | | | 1 | i | - |
| (4) Imployee was Working 3 Alone 3 With fellow workers | /O Years | mon at 1 me | | 12 | WT OPEN | Tuns | WASHBU | EN TURALL |
| nployee was Working Alone With fellow workers | | | or incident | | of Incident | Time of Incide | nt | Date Incident |
|] Alone] With fellow workers | | 6 | Months | 5. | 22-08 | 1615 0 | АМ [ЖРМ | Reported |
| With fellow workers | | | | | | yee's Workday | | ijury |
| | Regular | | ☐ Contract | | Performing \ | | | During Break Period |
| | Regular | | ☐ Tempora | ary | | eaving the Build | | During Meal Period |
| | _ 🗋 Non-em | ipioye e | | | W Other CE | ing premise | نا | Working Overtime |
| pecific Location of Incident | | | | | | D D- " " | | Vas it on the |
| ☐ Office ☐ Restroom | ☐ Elevator | | ☐ Lab ☐ Wareho | uiga April | | Press Building Storage Building | | mployer's Premises' |
| _ Restroom ☑ Parking Area | ☐ Office Ground | ds | Lift Stati | | | Storage Bonding Blower Room | 3 | Yes 🗀 No |
| Hallway . | Meeting Room | | Aeration | n Area | <u> </u> | Disinfection Area | a | |
|] Sidewalk | ☐ Vehicle | | Clarifier | | | Other | | |
|] Photocopy Room] Break Room | ☐ Tank Farm ☐ Control Buildi | lina | Pond # Digester | | - KAU | TOMATİL FI GAR | 2017 | |
| Stairs | ☐ Maintenance | | Lay Dov | | d | GATT | <u> </u> | |
| everity | | | | sition | | | S | ent to: |
| No apparent Injury | ☐ Medical Trea | atment | U D: | avs aw | ay from work #_ | | 1,- |] Hospital |
|] First Aid | ☐ Fatality | | | estricte | d work days # | | | |
| Lost Work Days | Other | | _ 🗆 Da | ate reti | urned to work | '' | 👨 | Doctor |
| Name and Address of Treatin | | | | | and Address of | | | |
| Phone # | | | | Phone | e # | | | |
| Describe the accident. What of paper) Please print neatly | CES TRANSPI | OUT TRUCK | L DIWERL | . A. | Kung Pale . D | i Rections - | ut Avio. | PRINT GATE - |
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| THE AL SHAM WILL | specific): | Equipmer | nt or Property | y Dam | aged? | vvnat cour | o you nave u | one to prevent this |
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| ody Part Affected (Be very | ſ | - | | | | | GATE A | 1953 · |
| ody Pall Allected (be very ! | mid Ho | _ | | | OFF. TRACK | Dale <u>5 · 26</u> | | <i>1264</i> · |

GCA Accident and Near Miss Report

Confidential Report, page 2

| Witness Statement (if applicable |) If more than one witness, atta | ich a separat | e sheet. | | |
|---|----------------------------------|---|--|---|--|
| Witness Signature and Date | | | PI | hone # | |
| Section 2To be completed in Supervisor's Description of Incide # This is not STARMITMU- II DO NOT ST Supervisor's Name and Signature | THE FIRST ACCIDENT OF - GATE COL | WESS, NEWT NESHHUU 18ES AL | TO DECUR BE D. CONSENER 27011ATSCALLY | | į |
| Supervisor's Name and Signature What corrditions of Looks, Equip the Incident As Hazardous Placement Ficors/Work Space Inadequate Ventilation Illumination Equipment Failure Inadequate Housekeeping | imen(-osVork-arasiContribi | ers hicle esign | //Whatcausedlocumuen | raining Defective on Illuminatio | Iftions (2) Substitution (2) Work Surtaces Guards/Barriers Tools/Equip/Vehicle |
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| Specific Corrective Actions or Corrective Action Taken | Preventative Measures Take | Person Res | | Target Date | Date Completed |
| Supervisor' Signature My Mr Ley Safety Coordinator Signature Muleul C | Date 5 | 27-08 | Manager's Signature Received in HR by | Jece- | Date 5-27-04 Date |



Claim & Information Services P.O. Box 12029 Austin, TX 78711-2029

1-800-859-5995 (512) 224-3800 Fax (512) 224-3889

June 20, 2008

C E S ENVIRONMENTAL SERVI 4904 GRIGGS RD HOUSTON, TX 77021-3208

Re: Claim #:

Employee: Soc. Sec.:

Employer: C E S ENVIRONMENTAL SERVI

FÁRRÍER RILEY

Date of Injury: 05/22/2008

DWC #:

In accordance with the Division of Workers' Compensation Rules, we are requesting that you submit the information indicated below. The DWC3 and DWC6 forms are available for printing from our website, www.texasmutual.com, under services, or from the division's website, www.tdi.state.tx.us. For your convenience, a DWC3 is now available for you to complete and submit on-line. It is located on our website, www.texasmutual.com under the Employers - Loss Run & Claims Detail Section. If you need assistance with filing the DWC3 on-line please contact me. If you do not have access to the Internet, we will be happy to send you a blank form.

| Contact ii | in you do not have access to the memor, we will be happy to send you a blank form. |
|-------------|---|
| | DWC3 EMPLOYER'S WAGE STATEMENT (Rule 128.2) - Please fax or email attachment or use the on-line version (www.texasmutual.com). |
| OR | DWC3SD EMPLOYER'S WAGE STATEMENT FOR SCHOOL DISTRICTS (Rule 128.7) |
| \boxtimes | DWC6 EMPLOYER'S SUPPLEMENTAL REPORT OF INJURY OR ILLNESS (Rule 120.3) - Please fax or email attachment. The following time frames apply. |
| | Within 10 days after: • The end of each pay period in which the employee's carnings have changed as a result of the injury, OR • The employee resigns or is terminated. Within 3 days after: • The employee begins to lose time from work as a result of the injury, OR • The employee returns to work, OR • The employee, after returning to work experiences an additional days(s) of disability as a result of the injury. |
| | provide the required information is an administrative violation and may result in the assessment of a penalty from the Division of Compensation. |
| | EMPLOYEE ACKNOWLEDGEMENT OF WORKERS' COMPENSATION NETWORK FORM (This form(s) shall be completed, signed and suhmitted). Please fax or send attachment via email as soon as possible. |
| | COPY OF THE POST-ACCIDENT DRUG SCREEN RESULTS |
| Thank yo | ou for your prompt attention to this matter. If you have any questions, please call me at 1-800-859-5995 ext. 2243. |

Debbie K Garrett WORKERS' COMPENSATION SPEC II

Sincerely,

Employee Acknowledgment of Workers' Compensation Network

I have received information that tells me how to get health care under my employer's workers' compensation insurance.

If I am hurt on the job and live in a service area described in this information, Lunderstand that:

- I. I must choose a treating doctor from the list of doctors in the network. Or, I may ask my HMO primary care physician to agree to serve as my treating doctor. If I select my HMO primary care physician as my treating doctor, I will call Texas Mutual at (800) 859-5995, extension 2880 to notify them of my choice.
- 2. I must go to my treating doctor for all health care for my injury. If I need a specialist, my treating doctor will refer me. If I need emergency care, I may go anywhere.
- 3. The insurance carrier will pay the treating doctor and other network providers.
- 4. I might have to pay the bill if I get health care from someone other than a network doctor without network approval.
- 5. Making a false or fraudulent workers' compensation claim is a crime that may result in fines and or imprisonment.

| Farrier Riley | 4/16/08 |
|--|------------------|
| Signature / | Date |
| Farrier Riley | |
| Printed Name | |
| I live at:(b) (4) | |
| Street Address | |
| (b) (4) | |
| City | State Zip Code |
| Name of Employer: <u>CES EMUINMENTA</u> | 1 Services, Inc. |
| Name of Network: Texas Star Network _{SM} | |
| Network service areas are subject to change. Call (800) 381-8067 if you need a network treati | ing provider. |
| Please indicate whether this is the: | |
| Initial Employee Notification | |
| Injury Notification (Date of Injury:/ | _/) |

DO NOT RETURN THIS FORM TO TEXAS MUTUAL INSURANCE COMPANY UNLESS REQUESTED

Employee Notice of Network Requirements - 03/06

Page 8 of 8





NOTIFICATION OF SUSPENSION OF INDEMNITY BENEFIT PAYMENT

DATE:

12/08/2008

TO:

RILEY, FARRIER

RE:

Date of Injury: Nature of Injury:

Part of Body Injured: Employee SSN:

DWC#:

Carrier Name:

Carrier Claim Number:

Employer:

05/22/2008 **CRUSHING**

ILTIPLE BODY PARTS(INCL.BODY SYSTEMS & BDY PARTS

Texas Mutual Insurance Company

C E S ENVIRONMENTAL SERVI 4904 GRIGGS RD

HOUSTON TX 77021-3208

We have suspended payment of Temporary Income Benefits effective 12/08/2008 because:

EMPLOYEE FAILED TO ATTEND DESIGNATED DOCTOR'S APPOINTMENT WITHOUT GOOD CAUSE.

You remain entitled to reasonable and necessary medical benefits related to this injury.

If you do not agree with the suspension of benefit payments, please contact me:

Adjuster's Name: Toll Free Telephone #: DEBBIE K. GARRETT (800) 859-5995 (512) 224-3889

Fax #/E-mail Address:

If we are unable to resolve the issue to your satisfaction, you may contact the Texas Department of Insurance, Division of Workers' Compensation for further assistance. You have the right to request a Benefit Review Conference. You can contact the Division office handling your claim at 1-800-252-7031.

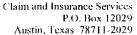
If you would like to receive notices such as this by facsimile or e-mail, please contact me and provide your facsimile number or e-mail address.

Please note that making a false or fraudulent workers' compensation claim is a crime that may result in fines and/or imprisonment.

RILEY, FARRIER

C E S ÉNVIRONMENTAL SERVI OGLETREE ABBOTT LAW FIRM

Spoke to Debbie Garrett and she said Riley is scheduled for a ductors appointment today.



BY:-----



NOTIFICATION OF SUSPENSION OF INDEMNITY BENEFIT PAYMENT

DATE: 12/29/2008

RE:

TO: RILEY, FARRIER

RILEY, FARRIER
(b) (4)

Carrier Claim Number:

Date of Injury: 05/22/2008 Nature of Injury: CRUSHING

Part of Body Injured: MULTIPLE BODY PARTS(INCL.BODY SYSTEMS & BDY PARTS

Employee SSN: (b) (4)
DWC #: 08272108

Carrier Name: Texas Mutual Insurance Company

Employer: CESENVIRONMENTAL SERVI

4904 GRIGGS RD HOUSTON TX 77021-3208

We have suspended payment of Temporary Income Benefits effective 12/29/2008 because:

MAXIMUM MEDICAL IMPROVEMENT WAS CERTIFIED BY THE DESIGNATED DOCTOR AS OF JULY 31, 2008 - 0% RATING ASSESSED.

You remain entitled to reasonable and necessary medical benefits related to this injury.

If you do not agree with the suspension of benefit payments, please contact me:

Adjuster's Name:
DEBBIE K. GARRETT
Toll Free Telephone #: (800) 859-5995
Fax #/E-mail Address: (512) 224-3889

If we are unable to resolve the issue to your satisfaction, you may contact the Texas Department of Insurance, Division of Workers' Compensation for further assistance. You have the right to request a Benefit Review Conference. You can contact the Division office handling your claim at 1-800-252-7031.

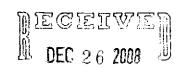
If you would like to receive notices such as this by facsimile or e-mail, please contact me and provide your facsimile number or e-mail address.

Please note that making a false or fraudulent workers' compensation claim is a crime that may result in fines and/or imprisonment.

CC RILEY, FARRIER
C E S ENVIRONMENTAL SERVI
OGLETREE ABBOTT LAW FIRM







TEXAS DEPARTMENT OF INSURANCE DIVISION OF WORKERS' COMPENSATION

Si prefiere hablar con una persona de habla hispana acerca de esta correspondencia o de su reclamo, sírvase llamar al 1-800-252-7031.

CES ENVIRONMENTAL INC 4904 GRIGGS RD HOUSTON, TX 77021-3208 December 23, 2008

Claim No: (b)

Docket No: 08272108-04-BR
Carrier No: 99J0000533279
Employee: FARRIER RILEY

Employer: CES ENVIRONMENTAL INC

CES ENVIRONMENTAL SERVICÉS INC

Date of

Injury: May 22, 2008

THIS LETTER IS SENT TO YOU FOR YOUR INFORMATION ONLY, AND DOES NOT REQUIRE ANY ACTION ON YOUR PART.

BENEFIT REVIEW CONFERENCE

DATE: January 20, 2009

TIME: 10:00 AM

PLACE: TDI-DIV WORKERS' COMPENSATION

2440 TEXAS PARKWAY, SUITE 240

MISSOURI CITY, TX 77489

(281) 403-7050

CONTESTED CASE HEARING:

TENTATIVE DATE: TO BE DETERMINED TIME & PLACE - TO BE DETERMINED

THIS CLAIM HAS BEEN SET FOR A BENEFIT REVIEW CONFERENCE

You are required to appear at this conference at the time and place stated above. The parties will attempt to resolve any disputes about this claim. A Division Ombudsman will contact unrepresented employees within two weeks to offer assistance in preparing for the conference.

The Benefit Review Conference is an informal meeting between an injured employee, the employee's designated representative (if any), and a representative of the incurence carrier. The employer is also entitled, but not required, to attend the conference. A Benefit Review Officer, who is an impartial Division employee, will also be present and will assist the parties in resolving the dispute. No testimony will be taken and no recording will be made.

The Benefit Review Officer will summarize the results of the conference. If all disputes are not resolved at this conference, the Division will hold a Contested Case Hearing. You will be advised by separate correspondence of the date, time, and location of the Contested Case Hearing.

Not later than 14 days before the conference, you must provide to all other parties and the Division field office handling the claim—copies of all written information relevant to the disputed issue or issues. If it is not possible to mail the information in time, bring enough copies to the conference to give to all parties.

DR01 (Rev. 11-05)

An Equal Opportunity Employer

If you wish to cancel or reschedule this conference, you must contact the Field Office at the address or telephone number below. A request to cancel or reschedule this conference must be made within 10 days after you receive this notice. A request received after 10 days may not be granted unless the Division determines there was good cause for the delay.

You are required to attend this conference. Failure to attend may result in an Administrative Violation and a penalty up to a maximum of \$500.

Sincerely,

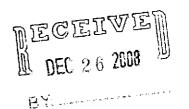
TDI-DIV WORKERS' COMPENSATION 2440 TEXAS PARKWAY, SUITE 240 MISSOURI CITY, TX 77489 (281)403-7050

THIS LETTER WAS ALSO SENT TO THE FOLLOWING:

FARRIER RILEY 12 OLD PRESIDIO DR MANVEL, TX 77578-5601

OGLETREE ABBOTT LAW FIRM LLP FYODOR D. CLAY 12600 N FEATHERWOOD DR STE 200 HOUSTON, TX 77034-4440

TEXAS MUTUAL INSURANCE CO PO BOX 12029 AUSTIN, TX 78711-2029





Division use

BY:_____

TEXAS DEPARTMENT OF INSURANCE DIVISION OF WORKERS' COMPENSATION

Si prefiere hablar con una persona de habla hispana acerca de esta correspondencia o de su reclamo, sírvase llamar al 1-800-252-7031.

CES ENVIRONMENTAL INC 4904 GRIGGS RD

HOUSTON, TX 77021-3208

December 22, 2008

Claim No: (b) (4)

Docket No: 08272108-03-cc

Carrier No: 99J0000533279

Employee: FARRIER RILEY

Employer: CES ENVIRONMENTAL INC

CES ENVIRONMENTAL SERVICES INC

Date of

Injury: May 22, 2008

INFORMATION ONLY, AND DOES NOT

REQUIRE ANY ACTION ON YOUR PART.

THIS LETTER IS SENT TO YOU FOR YOUR

CONTESTED CASE HEARING: DATE: February 4, 2009

TIME: 09:00 AM

PLACE:

TDI-DIV WORKERS' COMPENSATION

2440 TEXAS PARKWAY, SUITE 240

MISSOURI CITY, TX 77489

(281) 403-7050

THIS CLAIM HAS BEEN SET FOR A CONTESTED CASE HEARING

Attached is a copy of the Benefit Review Officer's report from the Benefit Review Conference. Since all disputed issues were not entirely resolved at the Benefit Review Conference, a Benefit Contested Case Hearing will be held as indicated above.

The remaining unresolved disputed issue(s) are identified in the report along with each party's position on the issue(s). Any party may make a written response to the unresolved dispute identified in the Benefit Review Officer's report. The response must be sent to the Division no later than 20 days after receiving this report must be delivered to all other parties.

A party may contact the Contested Case Hearing Officer prior to a scheduled hearing regarding procedural issues, but communication with the Hearing Officer regarding facts, issues, laws, or rules related to the claim is not allowed. The Division has adopted additional rules regarding subpoenas and discovery in Chapter 142 of the Texas Workers' Compensation Rules that may be useful in preparation for the hearing.

No later than 15 days after the Benefit Review Conference, all parties must exchange <u>all</u> medical reports, expert witness reports, witness statements, and any and all other documents that a party intends to offer into evidence at the hearing. All parties have a right to be represented by an attorney. If you are not currently represented but retain counsel for the Contested Case Hearing, advise your attorney to file the Letter of Representation with the Division field office handling the claim.

Failure to attend a Benefit Contested Case Hearing without good cause, as determined by the Hearing Officer, is a Class C Administrative Violation, with a penalty not to exceed \$1,000. If the parties resolve the disputed issue by settlement or agreement, and if the settlement or agreement is approved by the Division, cancellation may be granted.

As an alternative to the Benefit Contested Case Hearing, the parties may mutually agree to resolve their dispute in an Arbitration proceeding as provided by the Texas Labor Code § 410.004 and 410.104 through 410.121 and Chapter 144 of the Division Rules. An election to engage in Arbitration must be filed with the Division within 20 days of the Benefit Review Conference. Once this election is made and filed with the Division, it is binding and irrevocable and the Contested Case Hearing will be cancelled.

If you have any questions concerning the Contested Case Hearing or Arbitration, please contact the customer service representative in the Field Office handling your claim as soon as possible.

Sincerely,

Texas Department of Insurance Division of Workers' Compensation

THIS LETTER WAS ALSO SENT TO THE FOLLOWING:

FARRIER RILEY 12 OLD PRESIDIO DR MANVEL, TX 77578-5601 OGLETREE LAW FIRM CELINA M. RECALDE 12600 N FEATHERWOOD DR STE 200 HOUSTON, TX 77034-4450

TEXAS MUTUAL INSURANCE CO PO BOX 12029 AUSTIN, TX 78711-2029

TEXAS WORKERS' COMPENSATION FU CAROL DUKE PO BOX 12029 AUSTIN, TX 78711-2029



Benefit Review Conference Report

| Claim No.: | (b) (4) | | |
|---|------------------------------------|--|-----------------------|
| Docket No.: | MI-08272108-03-BR- | MI34 | |
| Carrier No.: | 99J0000533279 | | |
| Date of Injury: | 05/22/08 | | |
| Date of BRC: | 12/08/08 | | |
| Location of BRC: | Missouri City | | |
| Claimant/Assisted or Rep. by: | Farrier Riley / Celina F | Recalde, Attorney | |
| Employer/Assisted or Rep. by: | CES Environmental Se | ervices Inc. | |
| Carrier/Assisted or Rep. by: | Texas Mutual Insuranc | e Co. / Carol Duke, Ad | ljuster |
| The parties were notified that the on February 4, 2009 at 9:00 a.m. | | 9 | <u>-</u> · |
| ☑ The parties were provided <i>Notification</i> Review Conference (BRC). This includes continuance is the jurisdiction of the conte | The Division's Continuance | | |
| ☐ The parties were provided the Notice to Pa | rties - The Contested Case Hear | ing, pursuant to TEX. LABOR | R CODE ANN. §410.031. |
| ☑ The parties were provided the Notice to Par | ties - Arbitration, pursuant to TI | ex. labor code ann. §4 | 10.031. |
| Issues Resolved at the Benefit Re | view Conference: | | |
| Issue Code Disputed Iss | ue | Resol | ution |
| | | | |
| Dispute Resolution Disposition: [] Agreement signed at the Benef [] Interlocutory Order issued (see [] Special Accommodations: [] Other: | | - ` | (C-24). |
| Signed the 10th Day of December 2 | 2008 PEC N dec | EIVE) 26 2008 | |
| Aus Carson-Ol | Somer BY | ensian neren neren neren neren neren erren erren erren erren erren erren erren erren erren erren erren erren e | PDWDWC RECEIVED |
| 7 | | | 230 1 0 2006 |
| AURA GARZON-O'BRIEN, BENI | EFIT REVIEW OFFICE | R SHE | ECLERK OF PROCEEDINGS |

Docket No.:

MI-08272108-03-BR-MI34

Employee:

Farrier Riley

1 Issue Unresolved after the Benefit Review Conference:

| Issu | e Code | Disputed Issue |
|------|--------|---|
| : | C07 | Does the compensable injury of 05/22/08 extend to disc protrusion at L4-5, lumbar facet syndrome at L4-5, L5-S1, and to L5 radiculopathy? |

Claimant's Position: Based on the medical reports from Dr. Dent and Dr. Esses, the above conditions are related to the compensable injury.

Carrier's Position: The designated doctor evaluated the claimant for extent of injury and found that the above conditions are not related to the compensable injury. The report of the designated doctor is correct and has presumptive weight.



HY

Appeal Rights and Procedures Notice Sent to Parties

Information for Injured Employees from the Division of Workers' Compensation

Any party, including the injured employee, may appeal in writing any decision issued in a contested case hearing to the Appeals Panel of the Texas Department of the Insurance, Division of Workers' Compensation (TDI-DWC). The written appeal should explain why the injured employee or party believes the decision on each issue in the contested case hearing is wrong. If a party files an appeal, the other parties to the dispute must file a written response to the appeal. The response should explain why the party believes the decision is correct.

Ombudsman Assistance

If an injured employee has not hired an attorney and does not have any other type of representation, assistance is available from an Ombudsman. Ombudsmen can help an injured employee, free of charge, with their appeal or response to an appeal. Ombudsmen may not give legal advice, make any decisions for an injured employee or sign agreements or forms. Ombudsmen have sample forms for an appeal or a response to an appeal, and can help complete the forms. The forms are available in English and Spanish, and there is no charge for the forms. You may request Ombudsman assistance by calling 1-866-EZE-OTEC (1-866-393-6432). For more information on Ombudsman assistance see http://www.oicc.state.tx.us/topics.ornhudsman.html.

Appeals Panel Review Procedure

Appeals Panel Judges will review the appeal, any responses to the appeal, the hearing officer's decision, and the record from the contested case hearing.

The parties cannot attend any portion of the appeal review process. Unless the appeal clearly indicates there is a legal error, it is likely the decision of the hearing officer will not be reversed. Under Section 410.204(c) of the Texas Workers' Compensation Act, the Appeals Panel may only write a decision that reverses the decision of the hearing officer, otherwise the hearing officer's decision becomes the decision of the Appeals Panel. In more than 95 percent of all appeals, the hearing officer's decision is legally correct and becomes the decision of the Appeals Panel.

If a decision is written as a result of an appeal, the Appeals Panel will either:

This publication is a summary and is presented for informational purposes only. It is not a substitute for the statute and TDI-DWC rules. For questions about TDI-DWC rules, please call Customer Assistance at 1-800-252-7031. AP04-068G(3-08)

- "reverse and remand" the decision by returning it to the hearing officer, because it has been determined that corrective action must be taken by the hearing officer to reach a legally correct decision; or
- "reverse and render" by issuing a new decision when it is determined that that hearing officer's decision is against the great weight of the evidence presented, or that the hearing officer has misapplied the law and reached an incorrect result; in such case, a new decision is entered by the Appeals Panel.

If an appeal submitted by an injured employee or another party does not include clear reasons why an injured employee or party believes the hearing officer's decision is wrong, the review of the appeal will probably result in the hearing officer's decision becoming the final decision of the Appeals Panel.

Writing an Appeal or a Response to an Appeal

Any appeal received by TDI-DWC must explain why the party believes the decision in the contested case hearing is wrong. That explanation may include references to testimony and documents presented as evidence at the contested case hearing. Also, the explanation may include references to the Texas Workers' Compensation Act, TDI-DWC rules, court cases, other TDI-DWC Appeals Panel decisions, and the Appeals Panel Decision Manual.

A response to an appeal should explain why a party believes the decision issued in the contested case hearing is still correct. That explanation may include references to testimony and documents presented as evidence at the contested case hearing. Also, the explanation may include references to the Texas Workers' Compensation Act, TDI-DWC rules, court cases, other TDI-DWC Appeals Panel decisions, and the Appeals Panel Decision Manual.

Time Deadline to File an Appeal

A party has 15 days to file an appeal of a contested case hearing. The 15 days are counted starting on the day after the date the cover letter and decision is received by the injured employee and the other parties, not counting Saturdays and

For further assistance, call 1-800-252-7031 or visit www.tdi.state.tx.us

Appeal Rights and Procedures Notice Sent to Parties

Information for Injured Employees from the Division of Workers' Compensation

Page 2

Sundays and holidays listed in Section 662.003 of the Texas Government Code (the first day of January, New Year's Day; the third Monday in January, Martin Luther King, Jr. Day; the 19th day of January, State Confederate Heroes Day; the third Monday in February, President's Day; the second day of March, Texas Independence Day; Good Friday; the 21st day of April, San Jacinto Day; the last Monday in May, Memorial Day; the 19th day of June, Emancipation Day in Texas; the fourth day of July, Independence Day; the 27th day of August, Lyndon Baines Johnson Day; the first Monday in September, Labor Day; Rosh Hashanah; Yom Kippur; the 11th day of November, Veteran's Day; the fourth Thursday in November, Thanksgiving Day; the Friday after Thanksgiving Day; the 24th day of December; the 25th day of December, Christmas Day; and the 26th Day of December).

The start date of the 15-day period is:

- five days after the date of the cover letter or the next working day if the 5th day is not a working day, if it is mailed, unless the great weight of the evidence indicates otherwise;
- the same working day if the cover letter was faxed or sent electronically by the TDI-DWC during normal business hours;
- the next working day if the cover letter was faxed or sent electronically by the TDI-DWC, but not during normal business hours on a working day; or
- (for insurance carriers only) the next working day after the cover letter was placed in the insurance carrier's Austin representative box.

Time Deadline to File a Response to an Appeal

After an appeal is filed with the TDI-DWC, an injured employee and the other parties to the dispute have 15 days to file a response to that appeal. The 15 days are counted starting the day after an injured employee or other party receives an appeal filed by the other party, not counting Saturdays and Sundays and holidays listed in Section 662.003 of the Texas Government Code.

Filing an Appeal or a Response to an Appeal

An appeal or response to an appeal should be filed with the Chief Clerk of Proceedings in the TDI-DWC Central Office in Austin as stated in the cover letter. If an appeal or response to an appeal is filed in any of the TDI-DWC local offices, it may delay processing of the appeal or response to an appeal.

An appeal or response to an appeal must be filed within the 15-day deadline to be considered. A late appeal or response to an appeal will not be considered.

Serve the Other Party or Parties

An appeal or response to an appeal must be served on the other party or parties on the same day that the appeal or response to an appeal is filed with the TDI-DWC. To serve the other party means to give the other party or parties a copy of the appeal or response to an appeal. Serving an appeal or a response to an appeal must be by personal delivery, certified mail with return receipt requested, fax, or any other verifiable means of delivery to a home or business address. You are advised to maintain proof of the delivery.

A certificate that the other party or parties have been served must be included with the appeal or response to an appeal. Here is an example of such a certificate:

| "I hereby certify that I have on | this (date) day of |
|----------------------------------|--------------------------|
| | (year), served a copy of |
| the attached request for appea | l on |
| | the name of the other |
| party receiving the copy) by _ | |
| | _ (state the manner of |
| service). | |
| | " (Signature) |

Mail or Fax all Appeals and Responses to Appeals to:

Chief Clerk of Proceedings
Texas Department of Insurance
Division of Workers' Compensation
P.O. Box 17787

Austin, Texas 78744 512-804-4021 (fax number)

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WARNING NOTICE: Delivery of appeals to the Appeals Panel sent by certified mail through the United States Postal Service in some instances has taken 30 days before delivery to the Chief Clerk of Proceedings. As a result, those appeals which were not delivered within the 15-day deadline, were not considered and the hearing officer's decision became final.

If you choose to file an appeal with the Appeals Panel by certified mail through the United States Postal Service, we suggest you also send a copy of the appeal by regular mail or by fax to 512-804-4021.

Busployee - You are required to report your injury to your outployer within 30 days if your employer has workens' companiation insurance. You have the right to free unshance from the Tonin Workers' Compensation Commission and may be credited to certain medical and income benefics. For further information call your local Commission field office or ((800)-252-7031.



TEXAS WORKERS' COMPENSATION WORK STATUS REPORT

Trabujador - Fa necessarin que asted reporte su lesión a su empleador dentre de 30 tilas e partir del dia en que sa horisma, si au empleador libro seguno de subspansación pera trabajadores, la Compider Tejana de Compensación para Trabajadores lo afreca seletenda gratatas, umidén puede que usien large derecho à carros henfollos médicas y monetarios. Pera mayor información tiane a la oficina bool de la Comisión 1980-254-7031.

| DADTI ČENERAL NICABIJATION | HAHID SYED, M.D. | (tot Itduminasion bribóses ouiki | 1/12/19 | | |
|--|---|---|-----------------------------------|--|--|
| | Cline/Facility Namo | 9. Employer's Name | 41701 | | |
| | LLIED MEDICAL CENTERS | CES ENVIRONMENTAL | | | |
| 05/22/06 (b) (4) 7 | Circle Facility/Doctor Phone & Fas 13-785-2667/ 713/785-2659 | Employer's Fax # or Email Address (if ki (713) 748-8664 | 1 9 411) | | |
| i i | Cinic/Facility/Doctor Address (alreet address) 718 BELLAIRE DLVD | 11. Insurance Carrier TEXAS MUTUAL | | | |
| Citianing injury between gate and truck and | | 12. Carrier's Fee or Email Address (If know | mn) | | |
| i lailing to the ground. | OUSTON TX 77081 | (512) 224-3689 | , | | |
| | | | | | |
| PART II: WORK STATUS INFORMATION (FU | | FES AND DESCRIPTION IN 13(c) AS | APPLICABLE) | | |
| 13. The injured employee's medical condition result | • | | | | |
| (a) will allow the employee to return to work (b) will allow the employee to return to work (c) | as of 1/12/09 (date) with the restrictions in | dentified in PART III. which are | | | |
| expected to lest through 2//2/07 (date). | | | | | |
| (c) has prevented and still prevents the employ through (date). The following descriptions: | | | | | |
| | | | | | |
| PART III: ACTIVITY RESTRICTIONS! (ONLY | COMPLETE (F BOX 13(b) IS CHECKED) | | | | |
| 14. POSTURE RESTRICTIONS (if any): | 17. MOTION RESTRICTIONS (If any): | 19. MISC, RESTRICTIONS | (if any): | | |
| Max Hours per day: 0 2 4 6 8 Other | Max Hours per day: 0 2 4 6 B Other | ✓ Max hours per day of we | , , , | | |
| Standing | Walking | Sit/Stretch breaks of 1 | per HOUR | | |
| Sitting | Climb stairs/ladders | Must wear splint/cast at | work | | |
| Kneeling/Squatting | Grasp/Squeeze | Musi use cruiches et ell | limes | | |
| Bending/Stooping | Wrist flex/extension | No driving/operating hea | avy equipment | | |
| | Reaching | Can only drive automati | c transmission | | |
| Pushing/Pulling | Overhead Reaching | No work /hour | s/day work; | | |
| Twisting | | in extreme hot/cold | | | |
| Other: 15. RESTRICTIONS SPECIFIC TO (If applicable): | Keyboarding | at heights or on see | | | |
| _ | Other: | · · | _ | | |
| L Hand/Wrist R Hand/Wrist R Arm Neck | 18. LIFT/CARRY RESTRICTIONS (If any): | Must keep | J. | | |
| LArm | May not lift/carry objects more than 20 I | bs. Elevated LCI | ean & Dry | | |
| | for more than hours per day May not perform any lifting/carrying | Dressing changes nece | | | |
| L Foot/Ankle R Foot/Ankle | Other: | | saary at work | | |
| LOther: | J. Ottier. | — LINe Running 20. MEDICATION RESTRICT | CTICNE (Massa) | | |
| 16. OTHER RESTRICTIONS (if any); Patient is able to perform sedentary/light PDL | | Must take prescription n | | | |
| - attent is adid to politoriti sepanial Jingitti Oz. | | | '' | | |
| | | Advised to take over-the | | | |
| * These restrictions are based on the doctor's best under particular restriction does not apply, it should be disregar | rstanding of the employee's assential job functions. dad. If modified duly that maala these residcilons is | If a Medication may make d | | | |
| available, the patient should be considered to be off work. It as at work. | lots - these restrictions should be followed outside of t | work | <i>'</i> | | |
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| PART IV: TREATMENT/FOLLOW-UP APPO | | | | | |
| | pected Follow-up Services Include: | lawy um | | | |
| LUMBAR IVD 722,10 _ 🔚 E' | valuation by the treating doctor on 1 month fol | | : am/pm | | |
| 1 1 | aferral to/Consult with | on (date) at | | | |
| | hysical medicine X per week forweeks ste | | : am/pm | | |
| I I I | pecial studies (list): | on (date) at | : am/pm | | |
| Date / Time of Visit EMPLOYEE'S SIGNATURE | | of Type: Role of Doctor. | Treating doctor | | |
| 11/25/08 | | Initial Designated doctor Follow-up Carrier-selected RME | Referrel doctor Canaulting doctor | | |
| Discharge Time Favouer Rul | 24 11 - 1 1 1 1 1 1 1 1 1 1 | | Other doctor | | |
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| | 1884 (B) 1881 (BB) (BB) BIN BB) BB) BB) | | | | |
| /CC 73 (Rev. 07/04) Page 1 | 1881 JMJ 1481 1288 8810 881 8811 852 858 | TEXAS WORKERS' COMPENS | ATION COMMISSION | | |

TWCC 73 (Rev. 07/04) Page 1

TEXAS WORKERS' COMPENSATION COMMISSION



Date 1/2/09

C E S ENVIRONMENTAL SERVI 4904 GRIGGS RD HOUSTON, TX 770213208

A BRC has been scheduled for the claim indicated below:

Employee: RILEY, FARRIER

Claim Number: (b) (4)

Employer: C E S ENVIRONMENTAL SERVI

Date of Injury: 5/22/2008

DWC Number: 08272108

Docket Number: 08272108-04-BR

Adjuster: DEBBIE K. GARRETT Phone Number: 1-800-859-5995

BRC Date: 1/20/2009 BRC Time: 10:00 AM

Hearing Rep: Cheryl Thompson Phone Number: 713-376-1276

BRC Location: Division of Workers' Compensation - Missouri City

2440 Texas Parkway, Ste 240, Missouri City, TX, 77489

281-403-7050



Employee - You are required to report your injury to your employer within 30 days if your employer has workers' someonation learnesse. You have the right to the sentiative from the Taxas Workers' Companies to Commission and may be entitled to certain medical and tecomo benefits. For further information call your local Commission field office or 1(600)-252-7031.



TEXAS WORKERS' COMPENSATION WORK STATUS REPORT

Trabajador - Es necesario que usted reporte su terión a su empleador dentre de 30 újes a partir del día un que se lesioné, si su empleador ciene aeguro de compressación para trabajadores, le Comisión Tejane do Compressación para Trabajadores le oficeo adistentes grabillas, tembrién paede que valed seaga derecho a ciento berefacios médicas y monetarios. Para mayor información fierna e la ofituha local de la Comisión 1-909-252-7931.

| PART I: GENERAL INFORMATION | SHAHID SYED, M.D. | (tot dandwagou briboses owk) |
|---|---|--|
| 1. Injured Employee's Name | B. Clinic/Facility Name | 9. Employer's Name |
| RILEY, FARRIER DEWAYNE | ALLIED MEDICAL CENTERS | CES ENVIRONMENTAL |
| 2. Date of Injury 05/22/08 3. Social Security Number (5) (4) | 713-785-2667/ 713/785-2659 | 10. Employer's Fex# or Emell Address (If known) (713) 748-8654 |
| 4. Employee's Description of injury/Adoldent | , in the second | 11. Inturance Cerrier |
| Crushing injury between gate and truck and | 5718 BELLAIRE DLVD Cky Suie Zp | TEXAS MUTUAL |
| falling to the ground. | HOUSTON TX 77081 | 12. Ceffer's Fax # or Email Address (If known) (512) 224-3889 |
| | | |
| 13. The injured employee's medical condition re (a) will allow the employee to return to wo (b) will allow the employee to return to wo expected to least through 01/25/08 (dete). (c) has prevented and still prevents the em through (dete). The following de | rk as of(date) without restrictions. rk se of(date) with the restrictions is ployee from returning to work as of(ascribes how this injury prevents the employee from | Jentified in PART III, which are date) and is expected to continue |
| PART III: ACTIVITY RESTRICTIONS: (ON | | |
| 14. POSTURE RESTRICTIONS (if any): | 17. MOTION RESTRICTIONS (If any): | 19. MISC. RESTRICTIONS (if any): |
| Max Hours per day: 0 2 4 6 8 Other | Max Hours per day: 0 2 4 6 8 Other | Max hours per day of work: 8 hour |
| Standing | Welking | Sit/Stretch breaks of 1 per HOUR |
| Silling | Climb etairs/fadders | Must weer splint/cast at work |
| Kneeling/Squatting | Grasp/Squeeze | Must use crutches at all times |
| Bending/Stooping | Wrist flex/extension | No driving/operating heavy equipment |
| Pushing/Pulling | Reaching | Can only drive automatic transmission |
| Twisting | Overhead Reaching | □ No work / □ hours/day work: |
| Other: | Keyboarding | In extreme hot/cold environments |
| 15. RESTRICTIONS SPECIFIC TO (If applicable | | at heighte or on ecaffolding |
| L Hand/Wrist R Hand/Wrist | 18. LIFT/CARRY RESTRICTIONS (If any): | Must keep: |
| L Arm R Arm Neck | | |
| LLeg Rteg Z Back | May not lift/carry objects more than 20 lit | No skin contact with: |
| | for more than hours per day May not perform any lifting/carrying | Dreseing changes necessary et work |
| L Foot/Ankle R Foot/Ankle | Olher: | |
| LOther: 16. OTHER RESTRICTIONS (If any): | | No Running 20. MEDICATION RESTRICTIONS (If any); |
| Patient is able to perform sedentary/light PDL | | Must take prescription medication(s) |
| 1 with the ability personners and the personners are | | |
| | | Advised to take over-the-counter meds |
| certioular restriction does not apply. It should be disc | inderstanding of the employee's essential job functions, spanded, if modified duty that meats these restrictions is ris, Note - these restrictions should be followed outside of w | not I /conside automotivido la superi. |
| PART IV: TREATMENT/FOLLOW-UP AP | POINTMENT INFORMATION | |
| 21. Work injury Diagnosis Information: 22 | Expected Follow-up Services Include: | |
| | Evaluation by the treating doctor on1 month follows: | ow up (date) at : am/pm |
| _ LUMBAR IND 722.10 | Referral te/Consult with | on (date) at : am/pm |
| . <u>-</u> 📮 | Physical medicine X per week forweeks state | · · |
| | Special studies (list): | on (dete) et : am/pm |
| P | | em. At this time, no further medical care is anticipated. |
| Date / Time of Visit EMPLOYEE'S SIGNATURE | DOCTOR'S SIGNATURE VIN | Type: Role of Doctor: Treating doctor |
| 11/25/08 Overland Time | | ollow-up Carrier-selected RME Consulting doctor |
| Discharge Time | 14 11 -4 11 - L | TWCC-selected RME Dether doctor |
| | 7 | |
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| CC 73 (Rev. 07/04), Page 1 | <u> </u> | TEXAS WORKERS' COMPENSATION COMMISSION |

TWCC 73 (Rev. 07/04) Page 1

TEXAS WORKERS' COMPENSATION COMMISSION

Division use



TEXAS DEPARTMENT OF INSURANCE DIVISION OF WORKERS' COMPENSATION

Si prefiere hablar con una persona de habla hispana acerca de esta correspondencia o de su reclamo, sírvase llamar al 1-800-252-7031.

February 11, 2009

CES ENVIRONMENTAL INC 4904 GRIGGS RD HOUSTON, TX 77021-3208 Claim No:

Docket No: 08272108-03-CC

Carrier No: 99J0000533279 Employee: FARRIER RILEY

Employer: CES ENVIRONMENTAL INC

CES ENVIRONMENTAL SERVICES INC

THIS LETTER IS SENT TO YOU FOR YOUR INFORMATION ONLY, AND DOES NOT REQUIRE ANY ACTION ON YOUR PART.

Date of

Injury: May 22, 2008

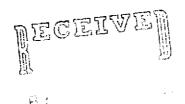
The Hearing Officer has reached a decision and entered an order in the above referenced claim. Copies of the decision and a fact sheet explaining what to do if you want to appeal this Hearing Officer's decision or if the other party appeals the decision are attached.

If you have questions or need help, please call or write to the field office shown in the letterhead above. To expedite the handling of requests for appeal and responses to requests for appeal, all correspondence should be addressed to the:

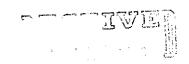
> APPEALS CLERK, HEARINGS TEXAS DEPARTMENT OF INSURANCE DIVISION OF WORKERS' COMPENSATION **POST OFFICE BOX 17787** AUSTIN, TEXAS 78744-7787

> > Sincerely,

Texas Department of Insurance Division of Workers' Compensation







TEXAS DEPARTMENT OF INSURANCE DIVISION OF WORKERS' COMPENSATION

Si prefiere hablar con una persona de habla hispana acerca de esta correspondencia o de su reclamo, sírvase llamar al 1-800-252-7031.

CES ENVIRONMENTAL INC 4904 GRIGGS RD HOUSTON, TX 77021-3208 November 20, 2008

Claim No: (b) (4)

Docket No: 08272108-03-BR

Carrier No: 99J0000533279

Employee: FARRIER RILEY

Employer: CES ENVIRONMENTAL INC

CES ENVIRONMENTAL SERVICES INC

Date of

Injury: May 22, 2008

THIS LETTER IS SENT TO YOU FOR YOUR INFORMATION ONLY, AND DOES NOT REQUIRE ANY ACTION ON YOUR PART.

BENEFIT REVIEW CONFERENCE

DATE: December 8, 2008

TIME: 10:45 AM

PLACE: TDI-DIV WORKERS' COMPENSATION

2440 TEXAS PARKWAY, SUITE 240

MISSOURI CITY, TX 77489

(281) 403-7050

CONTESTED CASE HEARING:

TENTATIVE DATE: TO BE DETERMINED TIME & PLACE - TO BE DETERMINED

THIS CLAIM HAS BEEN SET FOR A BENEFIT REVIEW CONFERENCE

You are required to appear at this conference at the time and place stated above. The parties will attempt to resolve any disputes about this claim. A Division Ombudsman will contact unrepresented employees within two weeks to offer assistance in preparing for the conference.

The Benefit Review Conference is an informal meeting between an injured employee, the employee's designated representative (if any), and a representative of the insurance carrier. The employer is also entitled, but not required, to attend the conference. A Benefit Review Officer, who is an impartial Division employee, will also be present and will assist the parties in resolving the dispute. No testimony will be taken and no recording will be made.

The Benefit Review Officer will summarize the results of the conference. If all disputes are not resolved at this conference, the Division will hold a Contested Case Hearing. You will be advised by separate correspondence of the date, time, and location of the Contested Case Hearing.

Not later than 14 days before the conference, you must provide to all other parties and the Division field office handling the claim—copies of all written information relevant to the disputed issue or issues. If it is not possible to mail the information in time, bring enough copir to the conference to give to all parties.

If you wish to cancel or reschedule this conference, you must contact the Field Office at the address or telephone number below. A request to cancel or reschedule this conference must be made within 10 days after you receive this notice. A request received after 10 days may not be granted unless the Division — determines there was good cause for the delay.

You are required to attend this conference. Failure to attend may result in an Administrative Violation and a penalty up to a maximum of \$500.

Sincerely,

TDI-DIV WORKERS' COMPENSATION 2440 TEXAS PARKWAY, SUITE 240 MISSOURI CITY, TX 77489 (281)403-7050

THIS LETTER WAS ALSO SENT TO THE FOLLOWING:

FARRIER RILEY 12 OLD PRESIDIO DR MANVEL, TX 77578-5601

OGLETREE ABBOTT LAW FIRM LLP FYODOR D. CLAY 12600 N FEATHERWOOD DR STE 200 HOUSTON, TX 77034-4440

TEXAS MUTUAL INSURANCE CO PO BOX 12029 AUSTIN, TX 78711-2029 Employee - You are required to report your oijury to your employer within 30 days if your employer (as workers' compensation instance. You have the right to free seletance from the Texas Workers' Compensation Commission and may be emitted to cettain medical and income benefits. For further information call your local Commission field office or I (800)-152-7031.



TEXAS WORKERS' COMPENSATION WORK STATUS REPORT

Trabajador - Es necesario que usitel reporte su lesión a su empleador denivo de 30 días a partir del día en que se lesione, al su emplasdor ilore agiavo de compensación para trabajadores. Is Crentido Tejano de Compensación para Trabajadores la ofrece asistencia grabula, temblén puede que usiast senga desecho a cierros beneficios médicos y monetarios. Para mayor información llame a la oficina local de la Cominión 1-800-2-92-7031

| ART I: GENERAL INFORMATION | 5. Gostofa Name and Degree SHAHID SYED, M.D. | (for kensmission purposes only) | Date Being Sent |
|---|--|--|--|
| njurad Employes's Name | B. Chris/Facility Name | B. Employer's Name | 12/25/0/ |
| ILEY, FARRIER DEWAYNE | ALLIED MEDICAL CENTERS | CES ENVIRONMENTAL | |
| 2Nii Af Mility 1 Sodal Saculty Number (5/22/08 | 7, Clinic/Facilly/Doctor Phone & Fax | 10. Employer's Fax # or Email Address ((713) 748-8664 | f known) |
| 5/22/08 (C) (4) Employee's DeacripHon of Injury/Accident | 713-785-2667/ 713/785-2650 6. Clinic/FeoNity/Doctor Address (street address) | 11. Injurance Certier | |
| rushing injury between gate and truck and | 5718 BELLAIRE DLVD | TEXAS MUTUAL | |
| iling to the ground. | Cily State Zip | 12. Carrier's Fax# or Email Addrsos (If k | по=п) |
| | HOUSTON TX 77081 | (512) 224-3889 | |
| i. The injured employee's medical condition re (a) will allow the employee to return to wo (b) will allow the employee to return to wo expected to last through (c) has prevented and still prevents the em | euiting from the workers' compensation injury: ork as of (date) without restrictions ork as of (date) with the restriction uplayee from returning to work as of ascribes how this injury prevents the imployee for | Identified in EART III, which are | 1 |
| ADT :: ACTIVITY DESTRUCTIONS: WIN | O M COMPLETE TO MAN ARRONDE STATE OF ST | | <u> </u> |
| ART THE ACTIVITY RESTRICTIONS (0) I, POSTURE RESTRICTIONS (If any): | 17. MOTION RESTRICTIONS (if any): | 19. MISC. RESTRICTION | NS (if any) |
| ax Hours par day: 0 2 4 6 9 Olher | Max Hours per day: 0 2 4 6 8 Other | Max hours per day of | |
| | | SivStretch breaks of | |
| anding | Walking | Must wear splint/cast | |
| ting LLLL | Climb stairs/ladders | Must use crutches at | |
| | Graso/Squeeze | □ No driving/operating i | |
| nding/Stoopingshing/Pulling | Wrist flex/extension | Can only drive automi | |
| Isting | Overhead Reaching | - □No work / □nc | |
| ner: | | in extreme havea | - |
| RESTRICTIONS SPECIFIC TO (If applicable | Keyboarding | et heights or an s | |
| _ | Other: | | |
| L Hand/Wrist R Hand/Wrist L Arm R Arm Neck | 18. LIFT/CARRY RESTRICTIONS (If any): | Must keep | |
| LLeg RLeg Back | May not lift/carry objects more than | ibs. Elevated DNo skin contact with: | Clean & Dry |
| | for more thenhours per day May not perform any lifting/carrying | Dressing changes nee | • |
| L Foot/Ankle R Foot/Ankle | Other: | 1 = | JOSEPH AL HANK |
| Other: | | - No Running 20. MEDICATION REST | PICTIONS (If any): |
| tient is able to perform sedentary/light PDL | | Must take prescription | |
| , , , , | | Advised to take over-1 | , |
| has a costructions and hasted on the doctor's how t | inderelanding of the employed's essential job functions | | |
| recular restriction does not apply, it should be distr | ogeriod, if modified duty that modes these restrictions in the Note - these restrictions should be followed outside of | a not (possible safety/driving is | |
| ART IV: TREATMENT/FOLLOW-UP AP | POINTMENT INFORMATION | | |
| Work Injury Diagnosis Information: 22 | Expected Follow-up Services Include: | | 1.1.0 |
| UMBAR IVD 722,10 | Evaluation by the treating doctor on1 month fo | llow up (dete) at | / 2 3/27/44 |
| -H | Referral to/Consult with | on (dale) at _ | : ampm— |
| <i>-</i> | Physical medicine X per week for weeks st | arting on(dete) at _ | : am/pm |
| F | Special studies (fist): | on(date) at _ | : an/pm |
| e / Time of Visit EMPLOYEE'S SIGNATURE | None. This is the last scrieduled visit for this prot | ilem. At this time, no further med sit Type: Role of Doctor. | cal care is anticipated // Resting doctor |
| 2/23/09 EMPLOYEES SIGNATURE | | Initial Designated doctor | Referrer pocto? |
| charge Time 4 R. Con. | / //// 4 | initial Designated doctor Dillow-up Carrier-sologied RME TWCC-selected RME | Other doctor |
| | | | |
| | | | |
| 0 | | | |
| 1841/128 1861 | | | |

TWCC 73 (Rev. 07/04) Page I

TEXAS WORKERS' COMPENSATION COMMISSION

THIS LETTER WAS ALSO SENT TO THE FOLLOWING:

FARRIER RILEY (b) (4)

TEXAS MUTUAL INSURANCE CO PO BOX 12029 AUSTIN, TX 78711-2029 OGLETREE ABBOTT LAW FIRM LLP FYODOR D. CLAY 12600 N FEATHERWOOD DR STE 200 HOUSTON, TX 77034-4440

LAW OFFICE OF GILBERT ATKINSON GILBERT ATKINSON 14520 MEMORIAL DR STE M # 150 HOUSTON, TX 77079-5427

CONFIDENTIAL Tex. Labor Code §402.083

TEXAS DEPARTMENT OF INSURANCE DIVISION OF WORKERS' COMPENSATION MISSOURI CITY FIELD OFFICE MISSOURI CITY, TEXAS

SE ENER

| FARRIER RILEY, | § | FEB 06 2006 |
|-----------------------------|--------|----------------------------|
| CLAIMANT | § 8 | THIS FLIERK OF PROCEEDINGS |
| v. | § | DUCKET NO. |
| TEXAS MUTUAL INSURANCE CO., | 9 § | MI/08272108/03-CC-MI43 |
| CARRIER | § § | |

DECISION AND ORDER

This case is decided pursuant to Chapter 410 of the Texas Workers' Compensation Act and Rules of the Division of Workers' Compensation adopted thereunder.

ISSUES

A benefit review conference was held on December 8, 2008 to mediate resolution of the disputed issue; however, the parties were unable to reach an agreement. A Benefit Contested Case Hearing was held on February 4, 2009 to decide the following disputed issue:

Does the compensable injury of May 22, 2008 extend to a disc protrusion at L4-5, lumbar facet arthropathy at L4-5 and L5-S1, and L5 radiculopathy?

PARTIES PRESENT

Claimant appeared and was represented by Fyodor Clay, attorney. Carrier appeared and was represented by Gilbert Atkinson, attorney.

BACKGROUND INFORMATION

It was undisputed that the Claimant sustained a compensable lumbar strain/sprain and left wrist injury while working for CES Environmental Services, Inc. on May 22, 2008. The evidence showed that the injury occurred when the Claimant, who was a truck driver for the employer, was making a delivery to a customer's plant, and while waiting at the entry gate to be admitted onto the grounds, was hit by the automatic gate, which caused him to be pinned against his truck, and in attempting to free himself from the motion of the gate, the Claimant violently twisted his lumbar spine. The extent issue herein turns on whether medical evidence establishes a causal connection between the delineated conditions and the Claimant's compensable May 22, 2008

12/07

Tex. Labor Code 8402.083

injury. After a review of the entire record, it is determined that the Claimant met his burden of proof, through the reports of Dr. David Dent and Dr. Stephen Esses, to show that the May 22, 2008 injury extends to and includes a disc protrusion at L4-5, lumbar facet arthropathy at L4-5 and L5-S1, and an L5 radiculopathy. The report of the designated doctor, Dr. Larry Skeete, is contrary to the preponderance of the evidence on this question of extent of injury to the lumbar spine, and the Claimant persuasively argued that it appears that Dr. Skeete did not fully appreciate the entire mechanism of his May 22, 2008 injury, namely the violent twisting of his low back that was involved.

Even though all the evidence presented was not discussed, it was considered. The Findings of Fact and Conclusions of Law are based on all of the evidence presented.

FINDINGS OF FACT

- 1. The parties stipulated to the following facts:
 - A. Venue is proper in the Missouri City Field Office of the Texas Department of Insurance, Division of Workers' Compensation.
 - B. On May 22, 2008, Claimant was the employee of CES Environmental Services, Inc., employer.
 - C. On May 22, 2008, employer had workers' compensation insurance coverage with Texas Mutual Insurance Co., Carrier.
 - D. On May 22, 2008, the Claimant sustained a compensable lumbar strain/sprain and left wrist injury while in the course and scope of his employment with CES Environmental Services, Inc.
- 2. The conditions of a disc protrusion at L4-5, lumbar facet arthropathy at L4-5 and L5-S1, and L5 radiculopathy in the Claimant's spine were caused or aggravated by, and naturally resulted from, his May 22, 2008 injury.
- 3. The Carrier delivered to Claimant a single document stating the true corporate name of the Carrier, and the name and street address of the Carrier's registered agent, which was admitted into evidence as Hearing Officer's Exhibit Number 2.

CONCLUSIONS OF LAW

- 1. The Texas Department of Insurance, Division of Workers' Compensation, has jurisdiction to hear this case.
- 2. Venue is proper in the Missouri City Field Office.

12/07

CONFIDENTIAL
Town Lighter Code

Tex. Labor Code §402.083

3. The Claimant's compensable May 22, 2008 injury extends to and includes a disc protrusion at L4-5, lumbar facet arthropathy at L4-5 and L5-S1, and L5 radiculopathy.

DECISION

The Claimant's compensable May 22, 2008 injury extends to and includes a disc protrusion at L4-5, lumbar facet arthropathy at L4-5 and L5-S1, and L5 radiculopathy. The Carrier is liable for compensation.

ORDER

The Carrier is **ORDERED** to pay medical benefits in accordance with this decision, the Act and the implementing Rules.

The true corporate name of the insurance carrier is **TEXAS MUTUAL INSURANCE CO.**, and the name and address of its registered agent for service of process is

RUSSELL RAY OLIVER, PRESIDENT 6210 HWY. 290 EAST AUSTIN, TX 78723

Signed this 6th day of February, 2009.

Patrice Fleming-Squirewell

Hearing Officer

DR

Appeal Rights and Procedures Notice Sent to Parties

Information for Injured Employees from the Division of Workers' Compensation

Any arty, including the injured employee, may appeal in writing any decision issued in a contested case hearing to the Appeals Panel of the Texas Department of the Insurance, Division of Workers' Compensation (TDI-DWC). The written appeal should explain why the injured employee or party believes the decision on each issue in the contested case hearing is wrong. If a party files an appeal, the other parties to the dispute must file a written response to the appeal. The response should explain why the party believes the decision is correct.

Ombudsman Assistance

If an injured employee has not hired an attorney and does not have any other type of representation, assistance is available from an Ombudsman. Ombudsmen can help an injured employee, free of charge, with their appeal or response to an appeal. Ombudsmen may not give legal advice, make my decisions for an injured employee or sign agreements or forms. Ombudsmen have sample forms for an appeal of a response to an appeal, and can help complete the forms. The forms are available in English and Spanish, and there is no charge for the forms. You may requisit Original assistance by calling 1-866-EZE-OTEC (1-866) 93-6432). For more information on Ombudsman a distance see <a href="http://www.oiec.state.tx.us/topics.ombuds.comb

Appeals Pane Review Procedure

Appeals Panel. Iges will review the appeal, any responses to the appeal, it hearing officer's decision, and the record from the context and case hearing.

The parties cannot attend any portion of the appeal review process. Unless I e appeal clearly indicates there is a legal error, it is likely the decision of the hearing officer will not be reversed. Under Section 410.204(c) of the Texas Workers' Computation Act, the Appeals Panel may only write a decision that reverses the decision of the hearing officer, otherwise the hearing officer's decision becomes the decision of the Appeals Panel. In more than 95 percent of all appeals, the hearing officer's decision is legally correct and becomes the decision of the Appeals Panel.

If a decision is wetten as a result of an appeal, the Appeals Panel will either

This publication is a summary and is presented for informational purposes only. It is not a substitute for the statute and TDI-DWC rules. For questions about TDI-DWC rules, please call Customer Assistance at 1-800-252-7031. AP04-068G(3-08)

- "reverse and remand" the decision by returning it to the hearing officer, because it has been determined that corrective action must be taken by the hearing officer to reach a legally correct decision; or
- "reverse and render" by issuing a new decision when it is determined that that hearing officer's decision is against the great weight of the evidence presented, or that the hearing officer has misapplied the law and reached an incorrect result; in such case, a new decision is entered by the Appeals anel.

If an appeal submitted by an injured employee or another party does not include clear reasons why an injured employee or party believes the hearing officer's decision is wrong, the inview of the appeal will probably result in the hearing officer's decision becoming the final decision of the Appeals Panet.

Writing an Appeal or a Respons : to an Appeal

Any appeal received by TDI-DWC must explain why the party believes the decision in the contested case hearing is wrong. That explanation may refude references to testimony and documents present I as evidence at the contested case hearing. Also, the evidence at the contested case hearing. Also, the evidence at the references to the Texas Workers' Covapensation Act, TDI-DWC rules, court cases, other TD -DWC Appeals Panel decisions, and the Appeals Panel Levision Manual.

A response to an appeal should explain why a party believes the decision issued in the contester case hearing is still correct. That explanation may include references to testimony and documents presenter as evidence at the contested case hearing. Also, the explanation may include references to the Texas Workers* Correpassion Act, TDI-DWC rules, court cases, other TDI-DWC Appeals Panel decisions, and the Appeals Panel Decision Manual.

Time Deadline to File an Appeal

A party has 15 days to file an appeal of a contested case hearing. The 15 days are counted starting on the day after the date the cover letter and decision is received by the injured employee and the other parties not counting Saturdays and

For further assistance, call 1-800-252-7031 or visit www.tdi.state.tx.us

Appeal Rights and Procedures Notice Sent to Parties

Information for Injured Employees from the Division of Workers' Compensation

Page 2

Sundays and holidays listed in Section 662.003 of the Texas Government Code (the first day of January, New Year's Day; the third Monday in January, Martin Luther King, Jr. Day; the 19th day of January, State Confederate Heroes Day; the third Monday in February, President's Day; the second day of March, Texas Independence Day; Good Friday; the 21st day of April, San Jacinto Day; the last Monday in May, Memorial Day; the 19th day of June, Emancipation Day in Texas; the fourth day of July, Independence Day; the 27th day of August, Lyndon Baines Johnson Day; the first Monday in September, Labor Day; Rosh Hashanah; Yom Kippur; the 11th day of November, Veteran's Day; the fourth Thursday in November, Thanksgiving Day; the Friday after Thanksgiving Day; the 24th day of December; the 25th day of December, Christmas Day; and the 26th Day of December).

The start date of the 15-day period is:

- five days after the date of the cover letter or the next working day if the 5th day is not a working day, if it is mailed, unless the great weight of the evidence indicates otherwise;
- the same working day if the cover letter was faxed or sent electronically by the TDI-DWC during normal business hours;
- the next working day if the cover letter was faxed or sent electronically by the TDI-DWC, but not during normal business hours on a working day; or
- (for insurance carriers only) the next working day after the cover letter was placed in the insurance carrier's Austin representative box.

Time Deadline to File a Response to an Appeal

After an appeal is filed with the TDI-DWC, an injured employee and the other parties to the dispute have 15 days to file a response to that appeal. The 15 days are counted starting the day after an injured employee or other party receives an appeal filed by the other party, not counting Saturdays and Sundays and holidays listed in Section 662.003 of the Texas Government Code.

Filing an Appeal or a Response to an Appeal

An appeal or response to an appeal should be filed with the Chief Clerk of Proceedings in the TDI-DWC Central Office in Austin as stated in the cover letter. If an appeal or response to an appeal is filed in any of the TDI-DWC local offices, it may delay processing of the appeal or response to an appeal.

An appeal or response to an appeal must be filed within the 15-day deadline to be considered. A late appeal or response to an appeal will not be considered.

Serve the Other Party or Parties

An appeal or response to an appeal must be served on the other party or parties on the same day that the appeal or response to an appeal is filed with the TDI-DWC. To serve the other party means to give the other party or parties a copy of the appeal or response to an appeal. Serving an appeal or a response to an appeal must be by personal delivery, certified mail with return receipt requested, fax, or any other verifiable means of delivery to a home or business address. You are advised to maintain proof of the delivery.

A certificate that the other party or parties have been served must be included with the appeal or response to an appeal. Here is an example of such a certificate:

| 'I hereby certify that I have on (month). | this (date) day of (year), served a copy of |
|---|---|
| ie attached request for appea | |
| | the name of the other |
| arty receiving the copy) by _ | |
| | _ (state the manner of |
| ervice). | |
| | " (Signature) |

1ail or Fax all Appeals and Responses to Appeals

, [

Thief Clerk of Proceedings

xas Department of Insurance

invision of Workers' Compensation

P.O. Box 17787

Austin, Texas 78744

> 12-804-4021(fax number)

WARNING NOTICE: Delivery of appeals to the Appeals
Panel sent by certified mail through the United States
Postal Service in some Instances has taken 30 days
before delivery to the Chief Clerk of Proceedings. As
a result, those appeals which were not delivered
within the 15-day deadline, were not considered and
the hearing officer's decision became final.

If you choose to file an appeal with the Appeals Pariel
by certified mail through the United States Postal Service, we suggest you also send a copy of the appeal
by regular mail or by fax to 512-804-4021.

and the second of the second o

Linguistics— You are required to report your injury to your employer within 30 days of your employer has workers' compensation bisurance. You have the right to free assignance from the Testa Department of Insurance, Division of Workers' Computantion and may be entitled to occupy medical and flowing branches. For further information cult your local Division field of Decision (500)-252-7031.



nagmana - ne nocosa se que se pare su resente a se empresario octavo de se para se se noma en que se lesionó si es que su empleador cuente can un registro de compensación para misignotes. Ustad riene derecho a regible avialencia gentala par parta de la División de Compensación para Tratsjada est, y tembrén puedo tener derecho a ciertos bestaficios médicas y monerarios. Para mayor información comuniquese con la oficias logal do la División al teléfono 1-400-252-7031.

| PARTI GENERA | | 6. Doctor's Name and Degree Dr. Shahid Syed, M.D. | (for trenamission purposes only) | Date Being Sen |
|---|--|--|---|-----------------|
| RILEY FARRIS | | 6. CVINICIPEACHILY NAME ALLIED MEDICAL CENTERS | B. Employers Name CES ENVIROMENT | 1 sold |
| Date of Injury | Social Socials Aluibby | 7 Clinic/Facility/Doctor Phone & Fax | 10. Employer's Fax # or Email Address (if | kāown) |
| 5/22/2008 Employee's Description | n of Injury/Accident | (713) 785-2667(713) 785-2659 B. Clinic/Factiny/Doctor Address (street address) | (713) 748-8664 17. Inaurence Carder | |
| Crusha | POLONY | 5718 BELLAIRE BLVD. | TEXAS MUTUAL | |
| | t gotte | City State Zip Houston TX, 77081 | 12. Carrier's Fax # or Email Address (if kn (512) 224-3889 | (nwc |
| ARTII: WORKS | TATUS INFORMATI | ON FULLY COMPLETE ONE INC. UDING PRIMATED | DATES AND DESCRIPTION IN 15(c) AS AR | PLICABLÉ: |
| 13. The injured emp (a) will allow the | ployee's medical condi | tion resulting from the workers' compensation inju to work as of(date) without restriction | Ury: | |
| | | to work as of (date) with the restriction | | |
| expected to last | through (d. | NFA) . | 4 - | |
| (c) has prevent | red and still pravente t | ne employee from returning to work as of | (date) and is expected to continue | • . |
| through 5,000 | Bulley | The state of the s | 60 MONTH | |
| | | (ONLY COMPLETE IF BOX 13(b) IS CHECKED) | | |
| _ | RICTIONS (if any): | 17. MOTION RESTRICTIONS (if any): | 19. MISC. RESTRICTIONS (| if any): |
| лая Hours per day; | 0 2 4 6 9 Other | Mex Hours per day: 0 2 4 6 8 Oth | Max hours per day of work | · |
| Standing | The state of the s | Walking | | per |
| Sitting | | Climb ateirs/ladders 🖂 🖂 🖂 🖳 | Must wear splint/cast at we | ark |
| (neeling/Squatting | | Grasp/Squeeze | Must use crutches at all tin | 195 |
| Bending/Stoaping 🗔 | | Wrist flex/extension ☐ ☐ ☐ ☐ ☐ ☐ | No driving/operating heavy | equipment |
| oshing/Pulling | | Reaching LCDDD | Can only drive automatic t | nolealmenar |
| wisting | 0000 <u> </u> | Overhead Reaching | 🗆 No work / 🗆 — bour | s/day work: |
| Pther. | | Keyboarding | In extreme hot/cold er | vironments |
| 5. RESTRICTIONS | SPECIFIC TO (if applic | able): Other: | at heights or on scaffd | al di ng |
| J L Hand/Wrist | ☐ R Hend/Wrist | 18. LIFT/CARRY RESTRICTIONS (if any | y): | ; |
| □ L Arm | □ RAm □ t | leck | | |
|] L'Leg | □ R Leg □ € | Beck for more than hours per day | □ No skin contact with: | |
| L Foot/Ankle | ☐ R Foot/Ankle | May not perform any lifting/carrying | ☐ Dressing changes necessary | ary at work |
|]_Other: | | | Ü No Running | |
| 6. OTHER RESTRI | ICTIONS (if any): | | 20. MEDICATION RESTRICT | IONS (If any); |
| | | | | dication(s) |
| | | | Advised to take over-the-c | ounter meda |
| | | est understanding of the employee's essential job function | | MBY |
| evallable, the patient sh | | disregarded. If modified duty that meets these restriction if work, Note - these restrictions should be followed outside | |) |
| is well as at work. | | | | |
| PART IV: TREAT | MENT/FOLLOW-UP | APPOINTMENT INFORMATION | | |
| 1. Work Injury Diag | gnosis Information: | 22 Expected Follow-up Services Include: | | |
| Lumba | | Evaluation by the treating doctor on | | |
| | | Referral to/Consult with | on (date) at | |
| 1 | | Physical medicine X per week forweeks | | |
| | | Special studies (list): | on (date) st | · |
| age./ Time of Visit | EMPLOYEE'S SIGNATU | None. This is the last scheduled visit for this p | A 0.0 T | |
| ZOIO | EWELDICE 3 SIGNATU | LE DOUTE SIGNATURE | Thister | Treating doctor |
| Incharge Time | 1 | | | Referral doctor |
| 3.127 | 4 | William I A Arr | ☐ Carrier-selected RME | |
| ~ W. | Tarrul | wey - 11-VIT'S | , TWCC-selected RME | J Other doctor |
| 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - | 111 | 0 (MM 1 () (1 M M 1) () (M 1 M 1 M M 1 M M 1 M M 1 M M 1 M M 1 M M 1 M M 1 M M 1 M M 1 M M 1 M M 1 M | f | |
| - ' | l i | ## | | : |
| DWC FORM-73 (R | tev,10/05) Page 1 | 81/88 (1): /88 00 (1) 881 8: 1151 (1351 881) 881 451 461 461 | DIVISION OF WORKERS' COM | PENSATION |

I implicee: Van are required in report your agary to your employer within 30 days if your on placer has workers' compensation insulance. You have the right to free assurance from the Less Deplacement of Jupitairee Division of Werkers' Compensation and large the entitled to company medical and more benefits. For Bothes information call your local Division field office or 1(800)-252-7031.



rampionari - en necessi si quo repaire se nomi i ne empessori sentro de su sues e perm de la recini en quo se lesionà si es que su empleador cuento con un seguro de compensación para trabajadores. Ustad tieno desceita o recibir neistencia princiale per parte de la División de Campensación para Trabajadores, y también puede coner derecita in ciertos tenefícios médicos y monetarios. Pura mayor información consentigose con la oficiale local de la División al relationo.

| 2. TEXAS WORKERS' COMPENSATION WORK STATUS REPORT | | | | | | |
|--|--|---|--|------------------|--|--|
| PARTI GENERA | LINFORMATION | 5. Occior's Name and Degree Dr. Shahld Syed, M.D. | (for transmission purposes snly) | Date Baing Sgnt | | |
| RILEY FARRIER | | ALLIED MEDICAL CENTER | Employer's Name CES ENVIROMENT | | | |
| 2 Date of Injury 5/22/2008 | Social Security Number XXX-XX- | Clinic/Fedilly/Doctor Phone & Fex (713) 785-2667(713) 785-2659 | 10. Employer's Fex # or Email Address (if known) (713) 748-8664 | | | |
| a Employee's Description | wan car | 6. Climc/Facility/Doctor Address (atreet address) 5716 BELLAIRE BLVO | 11. Insurance Carrier TEXAS MUTUAL | | | |
| | hal | City State Zp Hauston TX, 77061 | 12. Camer's Fex # or Email Address (if known) (812) 224-3899 | | | |
| PART II: WORK STATUS INFORMATION (FULLY COMPLETE ONE INCLUDING ESTIMATED DATES AND DESCRIPTION IN TROJUGA BAPPLICABLE) | | | | | | |
| 13. The injured employee's medical condition resulting from the workers' compensation injury: | | | | | | |
| (date) with allow the employee to return to work as of(date) with the restrictions identified in PART III, which are | | | | | | |
| pacted to last | through (date). | e la como | | , | | |
| (c) has prevented and still prevents the employee from returning to work as of through (date) and is expected to continue through (date). The following describes how this injury prevents the employee from returning to work: | | | | | | |
| | | | | | | |
| 14. POSTURE REST | | Y COMPLETE IT BOX 13(b) IS CHECKED) 17. MOTION RESTRICTIONS (if any): | 19. MISC. RESTRICTIONS | S (if any); | | |
| Max Hours per day: | 0 2 4 6 8 Other | Max Hours per day; 0 2 4 6 8 Other | ☐ Max hours per day of w | ork: | | |
| Standing | מממומה | Walking | Sit/Stretch breaks of | | | |
| Sitting | D-11380 | Climb stairs/ladders 🗆 🗎 🗔 🖂 | ☐ Must weer eplint/cast at work | | | |
| Kneeling/Squatting | | Grasp/Squeeze | ☐ Must use crutches at all | times | | |
| Banding/Stooping 🗌 | | Wrist flex/extension 🗆 🗆 🗎 🗀 | No driving/operating has | avy equipment | | |
| Pushing/Pulling | 00003 — | Reaching DDDD | Can only drive automati | | | |
| Twisting | | Overheed Resching (1000) | □ No work / □ ——bx | - | | |
| Other: | SPECIFIC TO (if applicable): | Keyboarding | in extreme hot/cold | | | |
| | | Other: | at heights or on sea | - | | |
|] L Hand/Wrist | ☐ R Hand/Wrigt | ☐ May not Ilft/carry objects more thanib | ☐ Must keep s. ☐ Elevated ☐ CI | ean & Dry | | |
| l Lleg | ☐ R Leg ☐ Back | for more than hours per day | No skin contact with; | - | | |
| ☐ L Foot/Ankle | ☐ R Foot/Ankle | May not perform any lifting/carrying | Dressing changes neces | | | |
| Other: | E ITTOONALIE | Other: | _ ☐ No Running | ooding as thoris | | |
| 18. OTHER RESTRICTIONS (if any): | | | | | | |
| | | | ☐ Must take prescription in | nedication(s) | | |
| | | | Advised to take over-the | -counter meds | | |
| | based on the doctor's best und as not apply, it should be diaregi | _{lot} (.) Medication may make d | | | | |
| available, the patient should be considered to be off work. Note - these restrictions should be followed outside of work. (possible safety/driving issues) | | | | | | |
| | MENTIEGILI OW UD ARD | DINITMENT INCODMATION | | | | |
| PART IV: TREATMENT/FOLLOW-UP APPOINTMENT INFORMATION 21. Work Injury Diagnosis Information: 22 Expected Follow-up Services Include: | | | | | | |
| Evaluation by the treating doctor on (date) at : am/pm | | | | | | |
| Referral to/Consult with on (date) at : am/pm | | | | | | |
| Physical medicine 2x per week for _weeks starting on (date) at : am/pm | | | | | | |
| Special studies (list); on (date) at :am/pm | | | | | | |
| None. This is the last scheduled visit for this problem. At this time, no further medical care is anticipated. Date / Time of Visit EMPLOYEE'S SIGNATURE DOCTOR'S SIGNATURE Wisit Type: Role of Doctor's President of the Control of the Cont | | | | | | |
| - Indian Political Processing Section - Indianal Politic | | | | | | |
| Dischage Time | Discharge Time Designated doctor Designat | | | | | |
| 2:3011 | 2:30/11. TWCC-selected RME Consuming doctor | | | | | |
| | 1 | | - I WY CO-SQUECTED PAME | Oniol angle. | | |

DWC FORM-73 (Rev. 10/05) Page 1



Employee - You are registred to report your lajory to your employer within 30 days if your employer had workers' compensation insurance. You have the right to flor assistance from the Tessa Department of Internance, Division of Workers' Compensation and may be critical or certain modical and learnesses Division for further teformation cell your local Division field office or 1(800)-252-7031.



Empleseud - En recipios se que reconse a majorn a su empleseun escriv en no esta a partir de sa institue en que se empleseun cuenta con un seguro de compen ación para trabajadores. Usted tiene derecho a recibir militarela gratulta por parte de la División de Compensación para Trabajadores, y también piede tener derecho a claran beneficios médicos y mones atos. Para mayor información comuniquese con in oficina local de la División al teléfono 1.800-252-7031.

| 2. TEXAS WORKERS' COMPENS | ATION WORK STATUS REPORT | 1. 1 | | | |
|---|---|--|--|--|--|
| PART I: GENERAL INFORMATION | Dr. Shahid Syed, M.D. | (for transmission purposes tinly) | | | |
| | B. Clinic/Facility Nome ALLIED MEDICAL CENTER | 9. Employar's Name CES ENVIROMENT | | | |
| RILEY, FARRIER 2. Date of injury 3. Social Security Number | 7. Clinic/Feolity/Doggr Phone & Fex | 10. Employer's Fax & or Email Address (If known) | | | |
| 5/22/2008 XXX-XX- 4. Employee's Description of Injury/Accident | (713) 765-2667(713) 765-2659 Clinic/Fecility/Doctor Address (givest address) | (713) 745-8664 | | | |
| Mush Destuden | 5716 BÉLLAIRE BLVD | TEXAS MUTUAL | | | |
| gate + bruck | Sists Zip Houston TX, 77081 | 12. Carrier's Fax # or Email Addissa (# known) (512) 224-3889 | | | |
| | sulting from the workers' compensation injury: rk as of (dete) without restrictions. | identified in PART III, which are (date) and is expected to continue | | | |
| PART III: ACTIVITY RESTRICTIONS* (ONL | Y COMPLETE IF BOX 13(b) IS CHECKED) | | | | |
| 14, POSTURE RESTRICTIONS (If any): | 17. MOTION RESTRICTIONS (if any): | 19. MISC, RESTRICTIONS (if any): | | | |
| Max Hours per day: 0 2 4 6 6 Other | Max Hours per day: 0 2 4 6 6 Other | Max hours per day of work: | | | |
| Standing | Walking DDDD | ☐ Sit/Stretch breaks ofper | | | |
| Sitting DDDDD | Climb stairs/ladders 🗆 🗎 🗎 💮 | Must wear spilnt/cast at work | | | |
| Kneeling/Squatting | Greep/Squeeze | ☐ Must use crutches at all times | | | |
| Bending/Stooping [] | Wrist flex/extension 🗓 🗒 🗒 🗎 📗 | ☐ No driving/operating heavy equipment | | | |
| Pushing/Pulling | Reaching GGGG | Can only drive automatic transmission | | | |
| Twisting U O C | Overhead Reaching | ☐ No work / ☐ ——hours/day work: | | | |
| Other: | Keyboarding | ☐ In extreme hot/cold environments | | | |
| 15. RESTRICTIONS SPECIFIC TO (If applicable): | | at heights or on scaffolding | | | |
| D | 18. LIFT/CARRY RESTRICTIONS (If any): | | | | |
| L L Hand/Wrist | May not lift/carry objects more than 30 | bs. | | | |
| P70 - | . | No skin contact with: | | | |
| | for more thanhours per day May not perform any lifting/carrying | Dressing changes recessary at work | | | |
| Fact/Ankle R Foot/Ankle | Other: | ☐ Dressing changes I ecessary at work ☐ No Running | | | |
| 18, OTHER RESTRICTIONS (if any): | | 20. MEDICATION RESTRICTIONS (If any): | | | |
| On diana will | for then Daintes | Must take prescription medication(s) | | | |
| | | | | | |
| or a male | * These restrictions are based on the doctor's best understanding of the employee's essential job functions. If a | | | | |
| particular restriction dose not apply. It should be disregi available, the patient should be considered to be off work. as well as at work. | arded. If modified duty that meets these restrictions is Note - these restrictions should be followed outside of w | uoi – Medication may make drowsy | | | |
| PART IV: TREATMENT/FOLLOW-UP APPO | | | | | |
| | Expected Follow-up Services Include: | (data) - t | | | |
| Evaluation by the treating doctor on(date) at am/pm | | | | | |
| | Referral to/Consult with | | | | |
| | Special studies (list): | (date) at : am/pm on | | | |
| 1 | | tem. At this time, no further middical care is anticipated. | | | |
| Date / Jime (Jime (EMPLOYEE'S SIGNATURE | | alt Type: Role of Doctor: Treating doctor | | | |
| 7/6/01 | | Initial Designated doctor Referred doctor | | | |
| Drackarge Time | 1 1 1 - A | Follow-up | | | |
| Farrier Kil | (ou) // w/4 / // | TWCC-selected fIME D Other doctor | | | |
| - resource 120 | 1 1 | TO 11100-SOIGNOUT (SEE TO OURS) BOLDS | | | |
| DWC FORM-73 (Rev.10/05) Page 1 | | DIVISION OF WORKERS' COMPENSATION | | | |